U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 13 July 2004

GARNETT C. MURRAY
2003-LHC-01015
OWCP No. 06-185362

Claimant

v.

UNIVERSAL MARITIME SERVICE COMPANY
Employer

and

SIGNAL MUTUAL INDEMNITY ASSOCIATION
Carrier

DECISION AND ORDER

This matter arises from a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. §§ 901, et seq., (the "Longshore Act" or "Act"), and the regulations promulgated thereunder. The Claimant is represented by Clifford Mermell, Esquire, Gillis and Mermell, of Miami, Flordia. Universal Maritime Service Company (hereinafter "Universal") and Signal Mutual Indemnity Association (hereinafter "Signal") are represented by Lawrence B. Craig III, Esquire, Valle and Craig, of Miami, Florida.

A hearing on this matter was held on November 18-19, 2003, in Fort Lauderdale, Florida. At hearing, six (6) administrative law judge exhibits, marked as ALJ 1-6, were admitted into evidence. (Tr. 4-5, 15). The Claimant offered six (6) exhibits (hereinafter referred to as "CX" 1-6). Tr. 44-47. The Employer/Carrier offered twenty four (24) exhibits (hereinafter referred to as "EX" 1, 4-18, 20-22, 27-29, 32).[1] Tr. 280, 282, 285, 287-290, 297. The Claimant testified at hearing. Live testimony was presented on behalf of the Employer by Dr. Alan Herskowitz, a board certified neurologist, and Ms. Rena Marvin, a vocational rehabilitation counselor. After receipt of the Hearing Transcript, both parties filed briefs. Although the Director did not attend the hearing, he did file a post-hearing brief on the Section 8(f) issue. The Employer subsequently filed a response to the Director's brief.

ISSUES

On March 22, 2001, Claimant was injured in a compensable accident when he sustained a crush and laceration injury to his left big toe. The following issues remain:

[1] I note that EX 2-3, 19, 23-25, 30-31 were never offered into evidence as Claimant's counsel and Employer's counsel agreed that these exhibits were duplicative of other exhibits already admitted into evidence.

(1) Claimant's right to first choice of physician[2]

(2) Maximum medical improvement

(3) Host of injuries other than the toe, including:
   (a) Lumbar spine (in conjunction with diabetic neuropathy and altered gait syndrome)
   (b) Diabetes mellitus
   (c) Diabetic retinopathy
   (d) Psychiatric claims

See Tr. 10-11; post-hearing briefs.

STIPULATIONS

The parties have agreed that:

(1) The average weekly wage ("AWW") is $1082.50, with a corresponding compensation rate of $721.66.

(2) The date of injury is March 22, 2001.

(3) The injury (with respect to the toe only) occurred within the course of Claimant's employment.

(4) The Notice of Injury was timely filed.

(5) The claim for benefits (with respect to the fracture of the toe only) was timely filed.

(6) The Employer is properly named.

(7) The Employer paid temporary total disability payments from March 23, 2001 through April 5, 2001, for a total of $1443.32.

(8) The Employer paid temporary total disability payments from June 5, 2001 through February 26, 2002, for a total of $27,526.28.

[2] The Claimant initially received treatment for his left great toe from Dr. Potash of the Port of Miami Medical Clinic, who "sutured up" Claimant's toe and sent him back to work weeks after the accident. Tr. at 22. Because he was still experiencing pain with his toe, Claimant of his own volition went to see his family physician, Dr. Pardell on May 15, 2001. CX 2:6. Dr. Pardell then sent Claimant to a foot specialist, Dr. Galitz. *Id*. at 9. Thereafter, Claimant was treated for his toe injury by Dr. Galitz. *See* CX 3. At hearing, Claimant's attorney indicated that "care and treatment was authorized and paid for with regard to the toe", but that Claimant "never did have his first choice of physicians…" Tr. at 10. However, it is unclear why Claimant's attorney raised this issue, since Claimant was examined and treated by a board certified foot surgeon of his very own choosing. I also note that this issue was never raised again in any of the post-hearing briefs or any other material submitted by the parties. I therefore find that this issue is moot.

(9) The Employer paid a scheduled injury award from February 27, 2002 through April 8, 2002, based on a three (3) percent impairment of the foot in the amount of $4438.21.

(10) The grand total of amounts paid is $33,407.06.

See Tr. 8-10, 12-13.[3]

FACTUAL BACKGROUND

Claimant testified on November 18, 2003, at the formal hearing. He stated that he was born in Jamaica on April 4, 1948. Tr. at 53. At the time of the hearing, he was fifty-five (55) years of age. *Id*. at 53. He testified that the extent of his education was through "primary school, six standard in Jamaica" and that he came to the United States in 1966 at age eighteen (18). *Id*. at 53. When he first arrived in the U.S., he worked for approximately two to three (2 to 3) years mowing lawns. *Id*. at 20, 54. He then worked as a maintenance man at Burdine's Department Store where he mopped floors for approximately three to four (3 to 4) years. *Id*. at 54.

Claimant testified that he next worked as a longshoreman with the Port of Miami, where he performed heavy, unskilled labor from approximately 1976 to 1988. Tr. at 20-21, 54-55, 59. He started as a longshoreman by working in the holds of ships where he loaded and unloaded cement and coffee beans; he eventually started working with the containers, loading and unloading the containers, lashing them down, and unlashing them. *Id*. at 21, 55. Claimant stated: "Well, lifting, like sometimes the load would be coffee beans. They were actually hundred pounds, but it's two of us lifting. So, we'd put them in the hold of the ship." *Id*. at 55. He testified that he performed this type of work for approximately fifteen (15) years, and that during this period he worked for about thirteen (13) different employers. *Id*. at 55. He also stated that during this period he worked about seventy (70) hours each week. *Id*. at 56. Claimant testified that during this period, his status with the union was that of "common laborer." *Id*. at 56. According to Claimant, this meant: "We don't have seniority. We're not in the union but we pay union dues, although we are not in the union." *Id*. at 56.

Claimant testified that during the fifteen (15) years he performed the work described above, he simultaneously worked "on and off" at the Miami International Airport as a porter handling baggage. *Id*. at 58-59. On December 12, 1988, Claimant was involved in an accident. *Id*. at 60.[4] With regard to the accident, Claimant testified: "I was working for a shipping company, Madura Shipping Company, and we were loading on board the ship, and the crane was lifting up the plywood and it catch underneath the side of the ship and it broke the cable and the

[3] The parties have also stipulated that this forum has jurisdiction over the claim. However, the issue of jurisdiction is a matter that does not lends itself to stipulation. After reviewing all of the evidence of record, I conclude that this forum has jurisdiction over the claim.

[4] Claimant testified that he recalled describing the accident in his prior deposition and that he revealed the details of the accident to all physicians involved in this case. Tr. at 60.

plywood scattered and it catch me and one of them hit me in the foot, fractured it. The next one hit me in the head and that's all." *Id*. at 60-61. On cross examination, Claimant specified that during this accident, he fractured his left ankle. *Id*. at 99. He also sustained a fracture of the jaw and received some head and low back injuries. *Id*. at 100. Claimant stated that as a result of the accident he was out of work for approximately four (4) years. *Id*. at 61. During that period, he received care for his back. *Id*. at 100. On cross examination, Claimant testified that he was hospitalized at Jackson Memorial Hospital for the low back and neck injuries he sustained in the 1988 accident. *Id*. at 102.

Claimant resumed working full-time at the Port of Miami from 1993 through March 22, 2001, the date of the accident at issue. *Id*. at 61. He described his work during this time period as "loading ships, unloading ships, containers." *Id*. at 61. Claimant stated that no physical problems prevented him from doing his job during this time period, and that he felt healed up from the injuries he sustained on December 22, 1988. *Id*. at 62. His doctor had allowed him to return to full duty heavy work. *Id*. at 62.

Claimant testified that he attained "seniority" [in the union] approximately six or seven (6 or 7) years before the March 22, 2001 accident. *Id*. at 62. Once he obtained seniority, Claimant was able to exert more control over his work schedule and conditions, and began earning approximately fifty or sixty thousand dollars ($50,000 or $60,000) per year. *Id*. at 21, 64-65.

In addition to the December 22, 1988 accident, Claimant testified that he also sustained a shoulder injury prior to the March 22, 2001 accident.[5] *Id*. at 66. Claimant testified that he thought he saw Dr. Potash for the shoulder injury but could not recall with certainty. *Id*. at 66. He also could not recall how much time he missed from work on account of the shoulder injury. *Id*. at 66. Claimant testified that he believed his company filed a claim for the shoulder injury but was not certain of that either. *Id*. at 67. On cross examination, Claimant testified that there was a period of time following that accident in July 2000 when he was out of work. *Id*. at 116.

Claimant then testified as to the injury that occurred on March 22, 2001.[6] *Id*. at 68. The following interchange between Claimant and his attorney relates to the sequence of events defining the accident:

> Q: Okay. What happened on March 22nd, 2001?
> A: On March 22, 2001, I was loading – unloading ship that came in for Universal Maritime, and we have to pull on all the lashing of the big ship. On that occasion, I was trying to pull a lock, and there was a lot of pressure on it, and as soon as I was turning it, it blows up into the air, the

[5] I note that Claimant's attorney was forced to refresh Claimant's memory in order for Claimant to recall the occurrence of this injury.

[6] In his opening statement, Claimant's attorney provided the following synopsis of the accident: While unlashing a container and removing the tie-down rods, one of the rods sprang out from the container and landed on the Claimant's left great toe and foot. Tr. at 22. The rod consisted of approximately forty five (45) to fifty (50) pounds of steel. Tr. at 22. The rod went through Claimant's shoe and lacerated his toe. Tr. at 22. The Claimant was sent to the emergency room.

pressure that was on it, it came right down and it landed on the shoes, and when it came down on the shoes, I fell forward to the ground.

Q: What – what – what was it that landed on your shoes?
A: The rod.
Q: What is that?
A: The rod that – steel rod that locked the containers down. It jumped off.
Q: How big is that rod?
A: The rod is – it's – I would say I don't know too much about it.
Q: How long was it? How long?
A: They have all different length rods.
Q: How long was this rod, approximately, if you can remember?
A: This one was the distance between the chair to the corner here.
Q: So, about eight feet long? Six feet long?
A: Six feet.
Q: Okay. And what did it weigh, approximately, if you know?
A: It was heavy. I don't quite remember.
Q: Okay. And so, it landed on what foot?
A: On the left foot.
Q: Okay. And you said you jolted forward?
A: Yes.
Q: And then what happened?
A: I don't know if my back I hurt, but I basically was hurting.

Tr. at 68-69.

After testifying as to the sequence of events defining the accident, Claimant provided testimony as to what he did moments after the accident. *Id*. at 69. He stated:

> So, I moved around to where the supervisor because I could hardly walk because I was in pain and I told him I got hurt, and he said come on, you've got to go to the office. I went to get down to the office, trying to take the shoes off because they were full of blood. I went to the supervisor's office, tried to get it off, and there was blood coming out, and he said we're going to see if we can clean it up, and he cleaned it up, but the more he was cleaning up, the blood was keep coming out, and he said got to go to the office, go to the doctor down by the clinic, Potash.

Tr. at 69.

Claimant testified that he subsequently went to see Dr. Potash, who "cleaned it up, put stitches on it, gave me some pain medicine and after he bandaged it up, then he told me to follow up the next day." *Id*. at 70. Regarding his visit to Dr. Potash, Claimant further stated: "He took an x-ray. After he took an x-ray, he put me into the whirlpool and he got it dressed after he stitch it up, then he gave me the pain pills to take and to return back the following day." *Id*. at 70. Although he could not recall precisely, Claimant testified that he treated with Dr. Potash for "some weeks." *Id*. at 70.

As to the problems Claimant experienced during the aftermath of the accident, he stated: "I was hurting down into the legs, and I told [Dr. Potash] my back start hurting me, and he said, 'It's time for you to go back to work.' I said, 'Doc, look at my foot. It's swelling and it's shiny, it's very swell. I have pain in my back going into the leg.' He said, 'I want you to go back to work, Mr. Murray. It's time for you to go back to work.' I said, 'Doc, I'm in a lot of pain in my back.' He said, 'I want you to go back to work with no restrictions,' and he gave me a yellow slip of paper to take back." *Id*. at 70-71.

Claimant testified that he returned to work in pain. At that time, he was limping and having trouble walking because his foot had swollen. *Id*. at 71. He stated that for about three (3) weeks, he continued to perform the same type of work as he had before the accident before he could no longer take the pain. *Id*. at 72. In May 2001, he went to see a different doctor, Dr. Pardell, who referred him to yet another doctor, Dr. Galitz. *Id*. at 72, 119. At the end of May 2001, Claimant went to see Dr. Galitz, who advised him that he required surgery right away. *Id*. at 73, 119. Claimant testified that Dr. Galitz thereafter performed surgery on July 17, 2001. *Id*. at 73, 120. After surgery, Claimant was limping and was put in a cast.[7] *Id*. at 73. He was also provided with a cane. *Id*. at 73. He was told not to put any weight on the injured foot for "several months." *Id*. at 73.

Claimant testified that he told Dr. Galitz that, in addition to his foot problem he was also experiencing back problems. *Id*. at 74. Claimant stated: "I was having severe pain down in my legs, in my back." *Id*. at 74. Although Dr. Galitz recommended treatment for his back, Claimant never received any such treatment. *Id*. at 74-75. Claimant stated that he also told Dr. Pardell, a physician who treated him primarily for his diabetes, about his back problems. *Id*. at 75-76. Specifically, Claimant testified: "I explained to [Dr. Pardell] that I was having a problem with my – with my back, and I cannot – I was falling down. I showed him where there were some cuts here when I fell down, and another time again I fell down twice and I was having problems." *Id*. at 75-76.

Claimant testified that prior to March 22, 2001, he never had any major side effects as a result of having diabetes, other than having to take medication to control his blood sugar levels. *Id*. at 76. Claimant stated that he was able to work full time, full duty with diabetes until March 22, 2001. *Id*. at 78. As far as he knew, he did not have high blood pressure prior to March 22, 2001. *Id*. He does recall Dr. Pardell diagnosing him with high blood pressure after the accident. *Id*. Prior to March 22, 2001, Claimant recalled taking one pill, glucophage, for his diabetes. *Id*. at 78-79. Claimant testified that after the accident, however, his "sugar started going up." *Id*. at 79.

With regard to vision problems prior to March 22, 2001, the only problem Claimant could recall was an episode that occurred while he was working on a passenger ship. *Id*. at 76. He stated: "It was like something got in my eyes, and when I step off the ship, so I notice there was more than one of us having that. Everybody was wondering what is wrong, and because quite a few guys, they had the same problem, I say, 'I can hardly see in the sun.' He said, 'I have the same problem.' So this guy says, 'It seems like it's pink eye.'" *Id*.

[7] Claimant could not recall how long he remained in a cast. Tr. at 73-74.

After this incident, Claimant decided to visit Bascom Palmer Eye Institute and Anne Bates Leach Eye Hospital, a part of Jackson Memorial Medical Center ("Bascom Palmer"), just to make certain that he did not have a vision problem. *Id*. Although he could not recall the date of his visit to Bascom Palmer, he testified that it was prior to March of 2001. *Id*. at 77. At Bascom Palmer, Claimant had his eyes checked and was given some eye drops and to ld to come back. *Id*. Claimant never returned, however, since his eyes were "okay in a couple of days." *Id*. He added that no one at Bascom Palmer ever told him he had diabetic retinopathy, nor any other serious eye problem. *Id*.

Claimant testified that six months after the March 22, 2001 accident, however, he could "hardly see, especially from the right eye." *Id*. at 79. He again went to Bascom Palmer where a retinal attachment (i.e. laser surgery) was performed. *Id*. at 80. Claimant could not recall whether at this point he became aware that his condition was diabetic retinopathy. *Id*. at 80-81. Every six months after his first retinal attachment, Claimant returned to Bascom Palmer. *Id*. at 81.

With regard to current vision problems, Claimant testified: "I lose sight in the right eye and the other one is going bad." *Id*. at 81. He claimed that he could not see anything out of his right eye such that when he closes his left eye "the whole place is dark." *Id*. at 81. Claimant stated that Bascom Palmer had helped to "bring [his left eye] back to a certain degree, but it's not all that good." *Id*. at 81. On cross examination, Claimant testified that no doctor has ever told him that his vision problems specifically resulted from the March 22, 2001 accident. *Id*. at 124.

Claimant then testified that Dr. Pardell recommended he see a psychiatrist because he could not concentrate or sleep at night. *Id*. at 82. In June 2002, Claimant went to see Dr. Garcia-Grande, a psychiatrist, who diagnosed Claimant with depression.[8] Claimant had never treated with a psychiatrist before the accident nor had he ever experienced depression or difficulty with concentrating, sleeping, or memory before the accident.[9] *Id*. at 85. After he saw Dr. Garcia-Grande, Claimant never received treatment for depression because he did not have the money for it. *Id*. He did see Dr. Garcia-Grande a second time, however, in September 2003.[10] *Id*. at 95.

Claimant testified that he was currently receiving social security benefits in the amount of approximately fifteen hundred (1500) dollars, payable every month. *Id*. at 96. He was also receiving benefits from the union in the amount of twelve hundred (1200) dollars each month. *Id*. at 97. Claimant testified that all medical bills he incurred with Dr. Pardell were paid by Humana Insurance Company. *Id*. at 97. On cross examination, Claimant admitted that he never checked with Humana to see if they would cover psychiatric care nor did he ask Dr. Grande what he would charge for psychiatric care. *Id*. at 98. In addition, Claimant admitted that in 1994, he

[8] On cross examination, Claimant was unclear as to whether Dr. Pardell (one of his physicians) or Mr. Mermell (his attorney in this case) recommended that he see Dr. Garcia Grande. *See* Tr. at 93-95.

[9] On cross examination, Claimant testified that, since 1988, no doctor has ever told him that his memory problems are a result of the impact that occurred in the 1988 accident. *Id*. at 125.

[10] From June 4, 2002 to September 10, 2003, Claimant did not make any efforts or discuss with Dr. Garcia-Grande or anyone else his return to his recommended care. Tr. at 99.

settled his claim regarding his 1988 accident for three hundred and seventy five thousand (375,000) dollars. *Id*. at 99.

Claimant stated that after the March 22, 2001 accident, Dr. Pardell started prescribing higher doses of medicine. *Id*. at 83. He also began taking three different medications for his diabetes as opposed to only glucophage. *Id*. Claimant testified that, because he was having memory problems, his wife handled his medications and administered them to him. *Id*. at 84. He believed that his memory problems stemmed from his difficulty concentrating and sleeping. *Id*. He further believed that his difficulty concentrating and sleeping stemmed from his pain. *Id*. at 84. He described the source of the pain as follows: "From my back. I don't know if it's going into my leg or it's coming from my leg, but both my back down into my leg [especially the left leg], my foot." *Id*. Claimant also stated that he continued to have pain in his left foot, "on the toe, coming up, and it's numb and very thick. Sometimes I have the pain sticking me like a needle inside." *Id*. at 85. While the pain in his left leg was worse, Claimant testified that he also had pain going down his right leg. *Id*.

Claimant testified that he had four (4) brothers and three (3) sisters, none of whom have diabetes or blood pressure. *Id*. at 86. His mother, however, did have diabetes though she never had vision problems. *Id*. Claimant had one child with his current wife. *Id*. The child was conceived before the March 22, 2001 accident. *Id*. at 86-87.

Other than the two (2) or three (3) weeks when Dr. Potash sent him back to work full duty, Claimant has not worked at all since March 22, 2001. *Id*. at 87. He felt that he would not be able to return to work as a longshoreman because he could not focus. *Id*. He stated: "I'm just worthless." *Id*. Claimant testified that he also could not handle physically the work of a longshoreman as there was no "light duty." *Id*. Moreover, he did not feel that there was any work that he could be performing at that time. *Id*. He had not developed skills in any other jobs other than loading and unloading containers and baggage. *Id*. at 88.

On cross examination, Claimant admitted that he had seen several physicians in connection with his current longshore claim at the behest of both his attorney and opposing counsel, but that he could not recall which of those physicians he told about the injury to his low back in 1988. *Id*. at 101-102.

On cross examination, Claimant admitted that he realized the importance of a diet for a diabetic, and that as a diabetic he should not drink alcohol. *Id*. at 113. He then admitted that he used to drink wine on occasion but that he had stopped doing so "some time about prior to being arrested." *Id*. Claimant then explained that he had been arrested for driving under the influence some time ago but that he could not recall exactly when.[11] *Id*. at 114-115.

[11] At the hearing, I stated for the record that I would not consider whether or not Claimant had a prior conviction of any kind and that I would void any information regarding the prior conviction provided in Claimant's testimony. Tr. at 115. The point of allowing Claimant to testify about his prior conviction was to clarify facts relating to his diabetes and hypertension. However, as it happened, this testimony did not serve this clarifying function.

On cross examination, Claimant could not recall spraining his back again in August 1994, sufficient enough that he missed work. *Id*. at 131. He also did not recall being put in pelvic traction as a result of his back complaints. *Id*. Claimant testified that, since March 2001, he had been in an automobile accident in which he rear-ended another automobile. *Id*. at 131-132. He admitted that the injuries in the accident were sufficient enough that he sought medical care at the hospital. *Id*. at 132. Claimant testified: "I was shook up and me and my wife and my baby was in the car, and I went to get a check-up." *Id*. Claimant also admitted that after the accident he followed up with a chiropractor, Dr. Gilchrist, who treated him for two (2) months for his pain and discomfort.[12] *Id*. at 132-133.

MEDICAL EVIDENCE

1. *Dr. Jeffrey L. Galitz*

Dr. Jeffrey Galitz testified on behalf of Claimant by way of deposition on October 28, 2003. He is board certified in foot surgery and specializes in both foot and ankle surgery. CX 1:4. Dr. Galitz first saw Claimant on May 29, 2001. *Id*. at 6. At that time, Claimant had received no significant treatment for his toe since the March 22, 2001 accident, and was actually back at work. Dr. Galitz testified, however, that there was no way Claimant could be working in any normal capacity at that time. *Id*. at 11. As a longshoreman, Claimant was expected to perform strenuous, high-risk tasks, and yet he had a fracture of the great left toe which is where sixty five (65) percent of one's weightbearing occurs. *Id*. at 12. On physical examination, Dr. Galitz observed that Claimant had tenderness surrounding his swollen left great toe, a very limited range of motion at the interphalangeal joint, a fungal infection of the left foot, and increased cooling of both feet. *Id*. at 6-7. A neurological exam revealed that Claimant had a decrease in sharp and dull sensation about the left great toe. *Id*. at 7. His range of motion and muscle strength were essentially within normal limits, except for the left great toe. *Id*. Additionally, vascular studies were essentially within normal limits, which would be consistent with the ability for a wound to heal itself or a surgical site to heal. *Id*. at 7, 37-38.

Dr. Galitz's impression at the time was that Claimant had a displaced fracture of the left great toe, which was not healing. *Id*. at 8. This essentially meant that a broken piece of bone had moved from its original location to a different location. *Id*. Dr. Galitz determined that an interphalangeal joint fusion of the left great toe was necessary. *Id*. He hoped that Claimant would be able to return to work full duty and resume his normal daily activities after the surgery, as would be the case in a successful interphalangeal joint fusion without any other compromising problems. *Id*. at 12, 39.

On July 17, 2001, Dr. Galitz performed toe surgery on Claimant. *Id*. at 9. The surgery consisted of an interphalangeal joint fusion using a screw over the left great toe. *Id*. Dr. Galitz explained that by removing the joint and fusing it, the pain of the joint is removed since it no longer exists. *Id*. at 10. He considered the surgery to be a success because it achieved its goal of

[12] Claimant testified that he complained only of shoulder pain to Dr. Gilchrist, not lower back pain as suggested by opposing counsel. Tr. at 133.

"fusion of the interphalangeal joint" and accomplished "appropriate position." *Id*. at 38. On July 24, 2001, Dr. Galitz saw Claimant for his first post-operative visit, which showed everything to be proceeding normally. *Id*. at 9-11. Claimant was in minimal discomfort, using his crutches (non-weightbearing), the skin edges were healing, and there were no signs of infection. *Id*. at 11. At this time, however, Claimant could not return to work as he was on non-weightbearing crutches. *Id*. at 12.

Claimant's next post-operative visit on August 1, 2001, was likewise normal. *Id*. at 13. Sutures were removed and Claimant was put in a below-knee cast. *Id*. Claimant's next post-operative visit on August 15, 2001, was likewise normal. *Id*. Claimant's next post-operative visit on August 29, 2001, was essentially normal. *Id*. at 14. He was continued on non-weightbearing crutches. *Id*. Claimant's next post-operative visit on September 12, 2001, was normal. *Id*. at 14-15.

At the next post-operative visit on October 2, 2001, Claimant stated that he was having occasional leg cramps but was otherwise without complaints. *Id*. at 15. Dr. Galitz noted that Claimant had a Vicryl foreign body reaction (i.e. an absorbable piece of suture material had been rejected by Claimant's body). *Id*. An x-ray revealed that the bones were fusing, which had been the whole purpose of the surgery. *Id*. at 15, 41. Claimant was continued on non-weightbearing crutches and prescribed a low-dose Valium for cramping. *Id*. at 16.

At the next post-operative visit on October 10, 2001, Dr. Galitz determined that Claimant had been clinically improving. *Id*. at 17. The plan was to discontinue the cast and put Claimant in a partial weightbearing, removable cast. *Id*. Claimant was to begin partial weightbearing on the foot, though he was still on crutches. *Id*. By the next postoperative visit on October 17, 2001, Claimant had been partial weightbearing but was a little unsteady. *Id*. at 18. The plan of treatment at that time included strapping the toe, putting Claimant in a surgical shoe, and continuing partial weightbearing status. *Id*. At the next post-operative visit on October 30, 2001, Dr. Galitz determined that Claimant was able to start normal shoe gear and increase his ambulation. *Id*. at 19. Claimant was to discontinue the use of crutches as of that date. *Id*.

At the next post-operative visit on November 13, 2001, Claimant had a complaint of radiating low back pain. *Id*. There was some soreness in the left great toe, and Claimant stated that he felt better in a surgical shoe rather than in a regular sneaker. *Id*. Walking in sneakers was hurting his lower back. *Id*. In addition, Claimant continued to complain of cramping. *Id*. While Dr. Galitz observed mild to moderate tenderness about the toe and minimal swelling, he testified that there was no clinical evidence of motion at the interphalangeal joint, which was an appropriate finding in a successful surgery. *Id*. At this point, Dr. Galitz opined that Claimant had low back pain, likely sciatica, and the plan was to refer Claimant to a physician for his back pain. *Id*. at 19-20. The Claimant was started on an anti-inflammatory and a muscle cream. *Id*. at 20. Dr. Galitz prepared to schedule removal of the screw from the toe. *Id*. At the next post-operative visit on November 20, 2001, the anti-inflammatory had apparently been helping Claimant's back, though he was still experiencing pain. *Id*. He also complained of continued cramping in the leg. *Id*. Dr. Galitz opined that the surgical site was stable but that Claimant was having sciatica. *Id*. He planned on getting approval for the screw removal and Claimant was maintained on anti-inflammatory. *Id*.

On December 6, 2001, Claimant underwent surgery a second time for the purpose of removing the screw from the toe. *Id*. at 23. Specifically, an incision was made so that the screw could be removed. *Id*. At the next visit, on December 13, 2001, Claimant stated that his toe was feeling fine but that he was still having pain in the back of the leg. *Id*. at 21. While Dr. Galitz observed that the condition of Claimant's foot was progressing normally, he wrote Claimant a prescription to see a physician for his back. *Id*. at 22. At the next postoperative visit on December 20, 2001, Claimant complained of pain in the back of the left leg. *Id*. With regard to Claimant's foot, however, the sutures were removed and the use of crutches from the second surgery were discontinued. *Id*. at 23. At the next postoperative visit on January 3, 2002, Claimant complained of continued leg pain on the left side and numbness of the feet. *Id*. Claimant demonstrated a decrease in sensation in the far ends of his leg and there was some mild tenderness of the left leg and calf, though there were no swollen veins. *Id*. at 23-24. Dr. Galitz opined that the Claimant was having leg pain, likely secondary to sciatica, but that the great toe was healing well. *Id*. at 23.

After the January 3, 2002 visit, Claimant was seen by Dr. Galitz about a month later. *Id*. at 24. Claimant complained of continued back pain and numbness in the leg. *Id*. His toe, however, was feeling better and he was wearing normal shoes. *Id*. Dr. Galitz opined that the surgical site had healed well, but that Claimant was having continued sciatica. *Id*. at 25. On February 7, 2002, Dr. Galitz discharged Claimant from his service and noted that Claimant could follow-up on an as-needed basis. *Id*. at 25, 46. He also noted that Claimant was to be followed up for his back. *Id*. Finally, Dr. Galitz noted that Claimant may need a custom-made insert for his shoe. *Id*. at 25. At this time, Dr. Galitz testified that Claimant was given the understanding that nothing further could be done to improve his condition. *Id*. at 54. Dr. Galitz did not see Claimant again until May 30, 2002, at which time Dr. Galitz observed that the fusion site had healed well but that Claimant was having continued back pain. *Id*. at 25-26. At that time, Dr. Galitz discharged Claimant from his service and opined that Claimant had reached maximum medical improvement (MMI) with respect to the left great toe, but that this was not respective of his lower back or any other problems he may have. *Id*. at 26.

When questioned as to whether Claimant's complaints of back pain with radiating leg pain and loss of sensation in the legs and feet could be causally connected to the March 22, 2001 accident, Dr. Galitz responded that such a question was "difficult to answer fully." *Id*. at 33. By that he meant that, while it is not uncommon for people who have foot trauma and are on crutches to develop back or lower hip pain, there are also people that have underlying back problems and are actually aggravating a preexisting condition under those circumstances. *Id*. at 33-34. Dr. Galitz testified that he did not know in this particular case; that Claimant's "sciatica may be from a bulging disk, it's hard to say." *Id*. Dr. Galitz went on to say:

> The numbness in Mr. Murray becomes more difficult to ascertain mostly because the fact that if this is a sciatic pain, then I would expect some numbness associated with that particular level of the lower back. However, Mr. Murray was also diabetic for a prolonged period of time, so it's not uncommon for diabetics of that length to develop some level of peripheral neuropathy.

> So, the numbness could be either from sciatica or his – or peripheral neuropathy from diabetes. Appropriate nerve conductions and neurological examination would best determine that.
>
> *Id*.

Notwithstanding that Dr. Galitz admitted his uncertainty regarding whether the numbness stemmed from sciatica or peripheral diabetes, he definitively disagreed with the statement of one physician who opined that, because Claimant lacked any symptoms going into his hands, it was unlikely that he suffered from diabetic neuropathy. *Id*. at 34. Specifically, Dr. Galitz testified that this was an erroneous assumption as he had seen "endless neuropathies … with patients who don't have hand symptoms." *Id*. Dr. Galitz stated that the "vast majority of people with peripheral neuropathy have zero hand symptoms and … can have significant lower extremity symptoms." *Id*.

Dr. Galitz testified that Claimant's last Independent Medical Examination (IME) was on May 15, 2002. *Id*. at 26. At that time, Claimant had been given a forty five (45) percent impairment rating of the great toe, which equated to eight (8) percent of the foot.[13] *Id*. Dr. Galitz further explained that eight (8) percent of the foot equals six (6) percent of the lower extremity, which amounts to two (2) percent of the whole person. *Id*. at 31. He testified that, to the extent that patient could tolerate prolonged walking or standing, he would not restrict the patient in terms of these activities. *Id*. Rather, restrictions would be imposed on an as-tolerated basis such that if Claimant developed ankle, foot, heel, or leg pain associated with prolonged ambulation, then restrictions would be imposed accordingly. *Id*. at 32. Dr. Galitz testified that ankle, foot, and leg pain could all potentially result from the patient's foot problem. *Id*.

Dr. Galitz testified that, with regard to altered gait, he would assign the lowest of the station and gait ratings to Claimant, which would be a five (5) percent of the whole person. *Id*. at 55. This rating would indicate that Claimant can stand and walk but may have difficulty with grade, steps and distances. *Id*. He also stated that, while the combined rating would therefore be seven (7) percent of the whole person (i.e two (2) percent from the foot plus five (5) percent from the altered gait), he did not think it appropriate at that particular time to assign such a figure because a certain amount of the gait disturbance may be also associated with the lower back. *Id*. Therefore, Dr. Galitz stated that he would have to defer to whoever treated Claimant's back. *Id*. He also stated that he could not discern how much of Claimant's gait difficulty was from the back, which may improve, or from a permanent disability secondary to the surgery and problem he had with his foot. *Id*.

Dr. Galitz testified that Claimant's diabetic condition did not interfere at all with any of the healing during the postoperative course of his toe surgery. *Id*. at 39. Specifically, Claimant healed at a normal rate without any complications, despite the multitude of complications that

[13] Dr. Galitz noted that he based these findings on the AMA Guide, Third Edition Revised. *See* CX 1: 27. Although this was not the most recent edition of the AMA Guide, it was the most recent edition that included the relevant information in that it specifically addressed the interphalangeal joint. *See* CX 1: 27-30.

can occur in diabetics. *Id*. at 40. Therefore, Dr. Galitz declined to refer Claimant to a diabetic physician. *Id*.

Dr. Galitz did not see Claimant again until May 30, 2002, at which time Dr. Galitz recalled that Claimant was depressed.[14] *Id*. at 25. Dr. Galitz did not refer Claimant to a physician for his depression, however, because he was hoping that Claimant's depression would decrease once he started becoming more functional. *Id*. at 52. Dr. Galitz noted that it was not uncommon for people to get depressed during long periods of healing. *Id*.

2. *Dr. Arthur Segall, Jr.*

Dr. Arthur Segall testified on behalf of Employer by way of deposition on October 24, 2003. He is board certified in podiatry and foot and ankle surgery. EX 18:4-5. Dr. Segall saw Claimant on October 14, 2003, at which time Claimant's chief complaint was painful left foot, leg, and lower back. *Id*. at 8. He performed a physical examination during which Claimant presented no apparent distress and appeared to be alert, oriented, and cooperative. *Id*. at 12. There were no behavioral abnormalities, such as crying, during the examination. *Id*. Examination of the integument, the skin, demonstrated nothing abnormal except the heel scar over the left big toe. *Id*. Vascular examination revealed no swelling. *Id*. at 13. The capillary filtai (i.e. the branching of the digits) was instantaneous, demonstrating no evidence of any decrease in blood circulation to the foot or the toes. *Id*. at 13-14. In addition, there was positive hair growth, which was also indicative of good circulation in the area. *Id*. at 14. The temperature of both feet was warm, which also demonstrates good circulation in the area. *Id*. Skin turgor, which deals with hydration of the skin, was normal and symmetrical on both feet. *Id*. There was no evidence of any blood clots, pressure, or pain in the calves or in the musculature of the legs. *Id*. Overall, Dr. Segall opined that Claimant's vascular examination indicated that "there was no apparent compromise" and that his circulation appeared to be "quite good." *Id*.

Dr. Segall also performed a neurological examination from which he observed that Claimant had decreased diffused sensations in both legs for light touch, sharp and dull, pretty much equal and symmetrical from one third of the leg down all the way to the ankle and the toes. *Id*. at 14-15. However, over the left big toe he appeared to have just a little more pain sensation upon direct location on the left big toe compared to the right big toe only. *Id*. The deep tendon reflexes, which also coincide with the neurological system of the Achilles and the patella, which is just below the knee, were slightly decreased at one (1) over forty (40). *Id*. One would expect "a little more of a jerk when palpitating these tendons." *Id*. With respect to these neurological findings, Dr. Segall opined that Claimant's left hallux complaints appeared to be the only ones related to the toe injury. *Id*. at 15. He also performed muscle testing, which showed "weakness on the left side at about minus four (4) over five (5)." *Id*. This meant that Claimant could "push

[14] Dr. Galitz had not recorded Claimant's depression in his notes, though his general practice is to record that type of information in his notes. Nevertheless, he recalled that Claimant was "very depressed" and "very upset" at that time.

with moderate resistance."[15] *Id*. at 16. He further stated that "on the opposite side, [Claimant] showed some slight decrease in muscle strength where it was just a little bit below normal against resistance." *Id*.

Claimant's range of motion appeared to be satisfactory on all claims, meaning that the ankle joint, subtalar joint, and metatarsal joint all appeared to be satisfactory and equal on both sides. *Id*. Although Claimant had no motion at the left interphalangeal joint, because it had been fused in a straight position from the surgery, there was motion at the joint below in the metatarsal interphalangeal joint, at the base of the big toe. *Id*. at 16-17. This was within normal limits. *Id*. at 17. The significance of the range of motion testing from a podiatric standpoint was to see if there was "any compromise in any other joints surrounding the injured area." *Id*. Dr. Segall found that there was no such compromise. *Id*.

With regard to his analysis of Claimant's gait, Dr. Segall observed that Claimant "walked in the office with antalgic gait, meaning favoring on the left side." *Id*. In addition, Claimant was using a cane on the left side. *Id*. There was "quite a bit of favoring." *Id*. There was good motion at the metatarsal phalangeal joint. *Id*. Dr. Segall observed that calf measurements were normal. *Id*. The clinical importance of normal calf measurements relates to the issue of muscle atrophy. *Id*. at 17-18. Dr. Segall stated: "If you don't use a limb or a body part for a period of time, the muscle will tend to weaken and get smaller. So I like to always compare to see how much decrease in muscle size has occurred over time due to the patient's injury, and I found no difference on either side." *Id*. at 18.

Dr. Segall testified that the findings with respect to the dermatome levels and the complaints of slight increase in pain over the left hallux were based on subjective responses given by Claimant. *Id*. He performed radiological studies, which showed a well-healed fusion of the interphalangeal joint of the left big toe. *Id*.

Dr. Segall testified that Claimant's diagnoses were as follows:

(1) Status post left hallux fracture/crush injury, work-related of 3/22/01.
(2) Subsequent post-traumatic arthritic changes of the interphalangeal joint secondary to work-related injury of 3/22/01.
(3) Subsequent fusion of said interphalangeal joint left foot and hallux secondary to work-related injury of 3/22/01.
(4) Subsequent removal of hardware left hallux secondary to work-related injury of 3/22/01.
(5) Continued pain of left lower extremity probably sciatica or radiculopathy not related to the left foot at this juncture.

Id. at 20.

[15] A result of five over five is normal, meaning that a patient can "push with quite a bit of strength against resistance." EX 18: 15-16.

He stated that the fusion, diagnosis number three (3), was performed to correct the post traumatic arthritic changes, diagnosis number two (2). *Id*. The diagnoses that had been made prior to his examination of the Claimant included the left hallux fracture, the post-traumatic arthritic changes, the fusion, and the removal of the hardware. *Id*. He testified that his basis for diagnosis five (5) was that on the straight leg test, Claimant seemed to demonstrate a positive straight leg sciatica test on the left side, which did not appear to "go all the way into the big toe." *Id*. at 21. He stated that Claimant's "big toe complaints appear to be isolated and different from those findings." *Id*.

In terms of recommended treatment, Dr. Segall opined that no further treatment was required with regard to the left big toe. *Id*. The basis for his view was that the fusion was well-maintained and he saw no vascular changes. *Id*. at 22. The scar was well-healed and he had some increased discomfort to the left big toe itself, which could be consistent with the injury and trauma and the fusion. *Id*. Other than that, however, Dr. Segall found "positive findings." *Id*. Dr. Segall recommended "additional work up from a neurologic or orthopedic standpoint" with regard to further treatment for Claimant's back. *Id*. at 21.

As of October 14, 2003, the date that he saw Claimant, Dr. Segall believed that Claimant had reached maximum medical improvement (MMI) for the toe injury. *Id*. at 22. Based on the American Medical Association (AMA) Guidelines, Fifth Edition, he opined that Claimant had sustained a four (4) percent impairment rating of the full person, which translated to a nine (9) percent impairment of the lower extremity, which translated to a thirteen (13) percent of the foot.[16] *Id*. With regard to the foot, Dr. Segall opined that Claimant should be able to work full duty without restrictions. *Id*. at 22-23. With respect to the complaints of sciatica or radiculopathy, Dr. Segall recommended that Claimant be followed up by a neurologist or back specialist. *Id*.

Dr. Segall opined that the toe injury did not have any effect on Claimant's diabetes. *Id*. at 24. The basis for his opinion was that Claimant's medical records showed that he had had problems with his diabetes stemming back to May 1999. *Id*. Thus, the effects of his diabetes over time, opined Dr. Segall, dated back to 1999 (i.e. before the date of the accident). *Id*. He also stated that he did not believe the diabetes had any significant effect on the toe injury. *Id*. at 26. The earliest date that he could detect problems with Claimant's diabetic management was March 9, 1991, when Claimant demonstrated a sugar level of two hundred and eighty seven (287). *Id*. at 24. The significance of this finding, according to Dr. Segall, was that "[s]ugar levels are used to elevate diabetic medical management, and sugar levels depending on the lab use normal or somewhere around 100, 110; and 287 is extremely elevated." *Id*.

3. *Dr. Jay G. Stein*

Dr. Jay G. Stein, a board certified orthopedic surgeon who examined Claimant for the Employer, wrote a medical report dated February 26, 2002. EX 7. In the report, he notes Claimant's previous accident in 1988. *Id*. at 7. He states that Claimant was out of work for four

[16] Dr. Segall testified that he could not state what these ratings translated to with respect to the toe because the AMA Guidelines, Fifth Edition, provide ratings only for the whole person, lower extremity, and foot.

(4) years and sustained a fractured jaw, a fracture of the left ankle, neck and back injuries. *Id*. The report notes that Claimant indicated that once he returned to work all symptoms in the neck, back, and left ankle had resolved and he went back to working full duty. *Id*. Claimant was treated at Jackson Memorial Hospital and had a long cast on his left leg, as well as therapy. Claimant denied other accidents or injuries. *Id*. He denied previous symptoms to the left foot region. *Id*.

Dr. Stein noted Claimant's diabetes medication, including Glucophage, Glipizide and Prinivil. *Id*. He also takes four (4) Tylenol #3 tablets per day, prescribed by Dr. Galitz, and Celebrex approximately two (2) tablets per day. *Id*. Claimant told Dr. Stein that his blood sugar had been unstable since the summer of 2001. *Id*. Two eye surgeries had been performed: Claimant stated that on the right eye, the retina was reattached and on the left eye, laser surgery was performed. *Id*. Other medical complaints at the time included dizziness and difficulty with balance. *Id*. Claimant noted that the cane assisted him. *Id*. Claimant described numbness about both feet, a sensation of swelling, and cramping in both feet. *Id*. Claimant also described back pain beginning after the accident which was worse at present. *Id*. Claimant stated that the symptoms "come and go." *Id*. Claimant stated that he sleeps three (3) hours with multiple interruptions nightly. *Id*.

With regard to the March 22, 2001, accident Claimant stated that a "long lashing bar became loose." *Id*. Claimant was not wearing steel toed shoes. *Id*. Claimant said that the bar crushed his left foot and he went to the Sunshine Clinic, where he said the wound was sutured and he continued to walk. *Id*. He said after returning to the clinic and a period of recovery, he was returned to work. *Id*. Working for three (3) weeks, he continued to have pain. *Id*. He was referred by Dr. Pardell to Dr. Galitz, a podiatrist. *Id*. He said he underwent x-rays and surgery in July and subsequent surgery in December to remove the screw. *Id*. Claimant said he had occasional aches about the left foot at present. *Id*.

The physical examination performed by Dr. Stein revealed that Claimant ambulated with a symmetrical flat-footed gait. *Id*. at 8. He did not step up on his left heels and toes. *Id*. The complaint of symptoms were about the lumbosacral joint. *Id*. Dr .Stein palpated no spasm. Claimant had full range of motion of the lumbar spine and normal straight leg raising. *Id*. Dr. Stein opined that Claimant had a permanent impairment of the left foot according to AMA Guide, Fourth Edition, a three (3) percent impairment of the foot. *Id*. at 9. He was at MMI from the injury and orthopedically can work on a regular and full time basis. *Id*. Dr. Stein did not believe that Claimant sustained a permanent injury to the lumbar spine. *Id*. He noted that the symptoms described appeared to be causally unrelated. *Id*. Dr. Stein further noted: "With the description of weight loss, diabetic management, instability, dizziness, as well as sleeplessness, it would appear that medical conditions unrelated to the incident of 3-22-01, are limiting [Claimant's] present level of functioning." *Id*. Dr. Stein opined that no further treatment was necessary with regard to the left foot injury sustained on account of the 3-22-01 accident. *Id*. He further opined that Claimant could work relevant to that foot injury in a regular and full time basis without limitation. *Id*. Dr. Stein mentioned, however, that Claimant's use of Tylenol #3 tablets may impair his judgment and functioning, since it is an opiate derivative. *Id*.

4. *Dr. Bruce D. Kohrman*

Dr. Bruce Kohrman testified on behalf of Claimant by way of deposition on November 6, 2003. He is board certified in psychiatry and neurology. CX 4 (attached exhibit). He saw Claimant on October 15, 2003. CX 4:5. He performed a general physical examination of Claimant, which showed Claimant to be "uncomfortable in appearance." *Id*. at 10. While Claimant's neck, thoracic spine, and lower back were normal, there was tenderness over the bones in the mid to lower lumbar spine. *Id*. There was also tenderness and muscle spasm in the left lumbar parasinous muscles (i.e. the big muscles in the low back on the left side). *Id*. There was tenderness elicited with palpation, when Dr. Kohrman pushed on the sacroiliac regions and the sciatic notch, which is the buttock on the left side. *Id*. The straight leg raising test was positive on the left side at eighty (80) to ninety (90) degrees, causing lower back pain. *Id*.

Dr. Kohrman also performed a neurological examination of Claimant, which showed his affect to be depressed. *Id*. at 11. He was blind in the right eye (an abnormal reaction of the pupil in the right eye was consistent with that). *Id*. There was paleness of the optic nerve in the right eye also consistent with that visual loss. *Id*. The sensory examination showed decreased pinprick sensation in the right leg below the ankle and in the left leg, more pronounced than in the right, with decreased pinprick sensation below the left knee. *Id*. The remainder of the sensory examination showed decreased vibratory sensation in the toes. *Id*. at 12.

Dr. Kohrman opined that, all of this taken together, in a man with a history of diabetes, shows some degree of diabetic nerve damage called diabetic neuropathy, present in both legs and feet. *Id*. This is generally what is expected to be symmetric; that is, equal on both sides. *Id*. In this case, it was worse on the left side. *Id*. Dr. Kohrman testified that the significance of these findings was that they were consistent with Claimant's injury. *Id*. Specifically, there was probably some superimposed traumatic injury, which may be coming from Claimant's low back. *Id*. Dr. Kohrman explained that this may be a lumbar radiculopathy, i.e. increased sensory loss in the left leg, or there may be a degree of local nerve injury from the trauma superimposed on his diabetic neuropathy. *Id*. Dr. Kohrman explained that Claimant had some degree of sensory loss in both feet. *Id*. at 27. Specifically, he stated: "The right foot was not injured. So if we take the right foot as the baseline, that would represent the degree of sensory loss related to generalized symmetrical proliferative neuropathy, which in his case was probably diabetes in origin. In addition to that, he has further loss of sensation in the left leg. That was not consistent with diabetes neuropathy, which is usually symmetrical in presentation." *Id*.

Dr. Kohrman explained the neurological significance of the evaluation of the lumbar spine as follows: "if he has objective evidence of a lumbar sprain syndrome; that is, he has pain tenderness and middle spasm in the lumbar spine on the left side, he has a positive straight leg raising test on the left side, which is a maneuver that may indicate a herniated disc or a pinched or irritated nerve in the low back or may relate simply to the muscle spasm in the back." *Id*. at 10-11. Claimant's reflexes were normal in the arms, symmetrically decreased at the knees and absent at the ankles. *Id*. at 13. This finding was consistent with diabetic neuropathy. *Id*. Other conditions that can cause absent reflex in the ankles are spinal disease and herniated disc – i.e. "if it were pushing on and irritating the nerves on both sides, the right and left, could cause decreased or absent ankles." *Id*. This is an objective neurological finding. *Id*.

Dr. Kohrman explained that Claimant had low back pain spreading into the buttock and down the back and side of the thigh down into the calf. *Id*. at 27-28. This was a classic syndrome of lumbar radiculopathy or sciatica. *Id*. at 28. Given these symptoms, and the findings in his left leg, it was either a nerve injury in the left or from a nerve injury in the back and for that reason, Dr. Kohrman recommended a nerve conducted EMG and lumbar spine MRI scan to help figure it out. *Id*.

Dr. Kohrman testified that the findings and sensation did not correlate exactly with a dermatonal pattern. *Id*. Dr. Kohrman explained the significance of this as follows: "It's nice when things do correlate exactly with a dermatonal pattern, but in clinical practice, in reality, things don't always follow that way. And sometimes it's difficult for patients to make distinct differentiations, especially if there may be some underlying neuropathy. We know he has diabetes neuropathy. So while he characterized the decreased sensation as more of a generalized decreased sensation below the knee, the fact is that there is decreased sensation on the left side below the knee. It's symmetrical compared to the right side." *Id*. at 28-29.

Dr. Kohrman admitted that, if there were no back pain and no pain radiating from the back down into the leg, then because it is not a dermatonal pattern, one might assume a proliferative or diabetes neuropathy over a lumbar radiculpathy. *Id*. at 29. He stated: "It would be more likely to be proliferative nerve injury, but in the setting in the context of very exquisitely and anatomically correct dermatonal radiation of pain from low back down into the left leg thigh and calf, that is a dermatonal distribution. That's a classic L5 or S-1 nerve root distribution. So in that setting, the decreased sensation in the left leg may very well be coming from low back." *Id*.

Dr. Kohrman testified that his characterization of the injury, a lumbar sprain with lumbar radioculopathy, is not necessarily considered to be a musculoskeletal injury. *Id*. at 31. He testified, rather: "But what I call lumbar sprain is low back pain, limitation of motion, muscle spasm and it may be purely an external musculoskeletal process or as I suspect in this patient, there is likely to be some underlying internal injury; for instance, a herniated disc, giving him the symptoms of lumbar radioculopathy of pain running down into the leg." *Id*.

Dr. Kohrman testified that Claimant's altered gait was yet another possibility for the "flare-up or for the cause of his low back pain." *Id*. at 34. He explained that Claimant's abnormal gait present since the injury had altered the normal biomechanics of the spine. *Id*. He stated that it was not uncommon for people to have a low back problem as a result of a prolonged alteration in their lumbar biomechanics. *Id*. In this specific instance, Claimant's foot injury and difficulty walking properly on the foot was another possibility for the flare-up or for the cause of his low back pain. *Id*.

Dr. Kohrman described Claimant's gait described as slow and antalgic, meaning painful with a limp on the left side; he was using a cane which helped him. *Id*. at 12. Claimant was unable to perform a tandem walk test, which is a heel to toe walk on a straight line. *Id*. Dr. Kohrman testified that there was no specific significance to this finding, though he did testify

that it was in part due to his back pain and in part due to his neuropathy (which was due to the decreased sensation in the feet). *Id*. at 12-13.

Dr. Kohrman opined that Claimant's low back, left leg, and left foot pain were causally connected to the March 22, 2001 accident. *Id*. at 14-15. As a result, he recommended that Claimant have a lumbar spine M.R.I. scan, a nerve conduction study and EMG of the left lower extremity. *Id*. at 15. He also recommended physical therapy, a psychiatry evaluation and ongoing treatment with psychotherapy and medication. *Id*. He suggested that Claimant's physical therapy be supervised by a physiatrist or a rehabilitation specialist and that if the lumbar spine M.R.I. scan showed a herniated disc or other compression of a nerve root, then Claimant might benefit from treatment with injections of lumbar epidural steroids. *Id*.

Dr. Kohrman testified on cross examination that he did not get any history from Claimant regarding whether there was any "jolting" or "jarring" involved in the injury, though he later testified on re-direct examination that it would be logical to assume, based on Claimant's description of the accident, that "something like that happened." *Id*. at 39. Specifically, he stated that "when a person has a sudden acute injury, it is often accompanied by a startled response, which sometimes causes neck injuries or sudden twisting avoidance type movements." *Id*. Moreover, Dr. Kohrman stated that "whether this was an acute injury, twisting injury to the low back, giving [Claimant] lower back and left leg pain radiating down from the low back down into the leg, as a result of this twisting type injury or whether this was the syndrome that developed as a result of abnormal lumbar biomechanics from his orthopedic injury, I can't sort that out at this point, but either of those two explanations is logically one that would explain his syndrome." *Id*. at 39-40.

With regard to whether Claimant had reached maximum medical improvement at the time that Dr. Kohrman saw Claimant, he opined that, while symptomatically Claimant had not been improving, he did not feel that he was neurologically MMI until the recommended diagnostic testing and treatment had been fulfilled. *Id*. He also stated, however, that if no further treatment is to be provided, or if treatment did not result in any improvement beyond his current condition, then he would consider Claimant MMI neurologically. *Id*. at 16. If he were to be considered currently at MMI from a neurological standpoint, Dr. Kohrman opined that for a diagnosis of lumbar sprain and left lumbar radiculopathy, ten (10) percent of the whole person, separate from any orthopedic rating that might apply for his left foot fracture. *Id*. at 16-17. Dr. Kohrman stated that he would defer to a psychiatrist for the rating regarding diagnosis of post traumatic depression and sleep disorder. *Id*. at 17.

Dr. Kohrman testified that with regard to the ten (10) percent rating that he assigned to Claimant, he did not assign any specific rating for the altered gait syndrome. *Id*. at 35. He did not believe there would be an additional rating attributable to that part of this injury separate from the combined orthopedic and neurologic impairment. *Id*. at 35-36.

Dr. Kohrman testified that Claimant did have physical restrictions and limitations from a working standpoint. *Id*. at 17. On a neurologic basis, Claimant's work would be restricted to sedentary or light duty. *Id*. No lifting more than ten (10) to fifteen (15) pounds, and no

repetitive activities of the lower back bending, lifting, pushing, pulling, squatting, stooping.[17] *Id*. He further testified that Claimant would not be able to return to his previous work which consisted of fairly heavy lifting loading and unloading ships. *Id*. at 18. Dr. Kohrman stated that if Claimant did not receive the recommended treatment or if the treatment did not improve his condition, than Claimant's restrictions and limitations would become permanent at that time. *Id*.

5. *Dr. Peter Millheiser*

Dr. Peter Millheiser testified on behalf of Employer by way of deposition on October 27, 2003. He is board certified orthopedic surgery. EX 19:6. He had been practicing orthopedic surgery for thirty (30) years until five (5) years prior when he decided to limit his practice solely to non-surgical orthopedics. *Id*. at 5.

Dr. Millheiser examined Claimant on October 7, 2003. *Id*. at 8. He noted that Claimant had severe intermittent pains, which were sharp in the low back and left great toe. *Id*. at 12. The back pain radiated down the left leg. *Id*. There was numbness and weakness in the left lower extremity. *Id*. The back pain was increased with bending, lifting, twisting, walking, sitting, standing and sleeping. *Id*. Claimant would fall because of left leg weakness. *Id*. He had pain in the left foot with standing fifteen (15) to twenty (20) minutes and walking a quarter of a block. *Id*. He had pain with moving the toes when he twisted the foot [i.e. when walking, sitting or standing]. *Id*. Claimant did not use any support other than a cane. *Id*. Claimant had not worked since about May 2001, and he mentioned that before the accident he would go out with his wife and traveled, and now he stayed at home. *Id*. His sleep was poor because of pain and anxiety. *Id*. He felt tense, irritable, anxious, nervous and down. *Id*. He had emotional problems and had seen a psychiatrist. *Id*. He did not smoke. *Id*. He denied relatives with back or severe pain problems or who were crippled or disabled. *Id*.

Dr. Millheiser performed a standard exam of the back, foot, and toe. *Id*. at 17. Claimant appeared to be "in no acute distress." *Id*. He walked with a flat foot gait and used a cane in his left hand. *Id*. With regard to the back, Dr. Millheiser noted that there was no lumbar tenderness and he had full range of motion in the lumbar spine. *Id*. There was no spasm, list, tilt or scoliosis. *Id*. He was not using a support. *Id*. Dr. Millheiser further testified that Claimant was not limping and there was no atrophy in the lower extremity. *Id*. at 18. There was no global hypesthesia or numbness of the entire left lower extremity, and hypesthesia of the right lower extremity from the knee distally. *Id*. There was giving away weakness in the left lower extremity. *Id*. Dr. Millheiser also found that there was no numbness in the hand, and that the knee and ankle reflex were equal and intact. *Id*. Straight leg raising was negative sitting and positive at about twenty (20) degrees on the left and forty five (45) degrees on the right. *Id*. There were various signs of over-exaggeration, including disparate straight leg raising, double thigh flexion, and Patrick signs. *Id*. Lumbar lordosis was normal and there were no trigger points. *Id*.

With respect to the left great toe, Dr. Millheiser noted a well-healed scar and that the "skin was shining." *Id*. He stated that the toe lacked ten (10) degrees of plantar flexion at the

[17] Dr. Kohrman clarified that the 10 to 15 pound limit would be a maximum occasional lifting.

metatarsal phalangeal ("MP") joint. *Id*. There was no motion at the interphalangeal ("IP") joint. Claimant had some mild toe tenderness. *Id*. X-rays showed a fusion of the IP joint of the big toe. *Id*. at 19. There was only one IP joint in the big toe as compared to the other toes. *Id*. There was some minimal degenerative changes at the MP joint. *Id*. Lumbar spine was unremarkable. *Id*.

In terms of the orthopedic significance of the findings of his exam, Dr. Millheiser testified as to the toe and the back separately. With respect to the toe, he found that Claimant had a fusion of the IP joint of the left great toe and had a little loss of restriction of motion at the MP joint. *Id*. With respect to the back, he found that there was "really no objective signs of injury." *Id*. Dr. Millheiser further stated that there was a considerable amount of over-exaggeration. *Id*. The global hypesthesia of the left lower extremity was not an objective finding. *Id*.

With regard to the right lower extremity, Dr. Millheiser noted that Claimant had hypesthesia from the knee down. *Id*. For diabetic neuropathy he should have had some hypesthesia in the hands, and there was none.[18] *Id*. There was giving way weakness in the left lower extremity, which Dr. Millheiser again pointed out was not an objective finding but an over-exaggeration and due to lack of cooperation. *Id*. at 19-20. A straight leg raising test was negative sitting, and positive with twenty eight (28) degrees on the left and forty five (45) degrees on the right when he was supine. *Id*. at 20. Dr. Millheiser explained:

> If it's negative sitting, it should be positive when someone's lying down. It's the exact same test. Except when they're sitting, you do not ask them does it hurt. When they're lying down, you say does this hurt. So if it doesn't hurt in a sitting position, it shouldn't hurt lying down. Also the double thigh flexion and Patrick signs do not cause, should not cause pain in the back. Flexion hips and knees relieves back pain, it doesn't increase it. And Patrick sign has nothing to do with the back, it's a test for hepatology. So there was considerable exaggeration in the back exam.

Id. at 20.

Dr. Millheiser's diagnosis was that Claimant had a fracture of the toe (a crush injury of the toe with a fusion) and low back pain by history. *Id*. With regard to whether Claimant had a permanent foot injury from the accident, Dr. Millheiser testified that the AMA Guide provides a rating for ankylosis, stiffness of the entire toe, of thirteen (13) percent of the foot, which equates to nine (9) percent of the lower extremity and four (4) percent of the body. *Id*. at 21. This rating, however, includes the MP joint as the main contributing factor in the stiff toe, whereas in this case, Claimant's MP joint was basically unaffected. *Id*. Dr. Millheiser opined that Claimant's

[18] On cross examination, Dr. Millheiser stated that his opinion that Claimant did not suffer from diabetic neuropathy was grounded in part on the fact there were no similar findings in the hand. He further stated that diabetic neuropathy is "usually quite symmetrical" and that it "may vary a little, but it doesn't involve the entire left lower extremity." Dr. Millheiser then stated that Claimant had numbness all the way up to the high thigh area on one side and the knee on the other side. According to Dr. Millheiser, it followed what was called a "glove and stocking paddle. The 99 atomic forms of numbness is also Wadell's finding."

impairment rating, if you extrapolate for an IP joint, is a lot less. *Id*. He determined that the impairment rating would be in the range of ten (10) percent of the toe, which is two (2) percent of the foot, which is (1) one percent of the lower extremity which is (1) one percent of the body. *Id*.

Dr. Millheiser also opined that Claimant did not have a permanent back injury as a result of the March 22, 2001 accident. *Id*. at 22-23, 48-49. When questioned as to whether there was any correlation between Claimant's back pain and the March 22, 2001 accident, Dr. Millheiser stated that he would defer to the medical records (which he had not seen). *Id*. at 22. He further stated that he would give Claimant the "benefit of the doubt" such that if Claimant complained of back pain and was being treated for it, then he would have no quarrel with such a finding. *Id*. Dr. Millheiser, however, did not observe residual problem or impairment from Claimant's back complaints. *Id*.

Dr. Millheiser testified that he did not believe Claimant required any further medical treatment. *Id*. at 23. As far as being a longshoreman, Dr. Millheiser stated that there was no reason that, from an orthopedic standpoint, Claimant would have any physical work restrictions or limitations to work. *Id*. Dr. Millheiser explained that his finding that Claimant had no restriction whatsoever was not inconsistent with the permanent impairment rating he assigned to Claimant because the rating involved the interphalangeal joint of the toe, and Claimant had no restrictions as far as walking, standing, bending, lifting, twisting, or any other activity that a longshoreman might reasonably do.[19] *Id*. at 49.

6. *Dr. Alan Herskowitz*

Dr. Alan Herskowitz testified at the formal hearing on November 18, 2003. He is board certified in neurology. Tr. 146. Dr. Herskowitz reviewed multiple medical records and depositions in preparation for his IME of Claimant. *Id*. at 153. The neurological significance of the records he reviewed was that they depicted "a multitude of injuries in the past, dating back to 1988, where [Claimant] had a lot of similar symptomatology and also … some medical problems with diabetes which also created some neurologic symptoms." *Id*. at 154. Dr. Herskowitz testified that he did not find any complaints of trauma to the back as a result of Claimant's March 22, 2001 injury. *Id*. Rather, the first time that Dr. Herkowitz noticed any back complaints mentioned in the medical records was "four or five months" after the March 22, 2001 accident. *Id*. Specifically, "low back pain" was mentioned. *Id*.

Dr. Herskowitz saw Claimant on October 24, 2003. Tr. 158. Dr. Herkowitz's testified that in recalling the events of the March 22, 2001 accident, Claimant stated that he did not fall to the ground. *Id*. at 155. Claimant complained of having pain radiating up and down his entire left leg and low back during the time that he was followed by the Port of Miami Medical Clinic after the accident. *Id* at 154.

[19] By contrast, he stated that "[i]f Claimant were a ballet dancer, I might feel that there could very well be some functional disability for a ballet dancer who has to point and get up on their big toe."

Dr. Herskowitz stated that Claimant complained of persistent low back pain, radiating down the whole left leg, with numbness of the entire left foot and poor balance, resulting in falling at times. *Id*. at 156. He used a cane to steady himself. *Id*. He did not sleep well at night because of the pain and was having some numbness on his right foot but not as pronounced as his left foot, and persistent pain in the left big toe. *Id*.

Although Claimant told Dr. Herkowitz that he was not aware of any previous back problems, Dr. Herskowitz had previously reviewed the medical records and knew to inquire about the 1988 accident where Claimant had some back pain and numbness of his feet. *Id*. Claimant then stated that his memory was bad and that he had been having more eye problems and memory problems, although he did not sustain any injury to his head in the fall. *Id*. at 156-157. Claimant also told Dr. Herskowitz of his fifteen (15)-year history of diabetes and that he had developed high blood pressure after the accident. *Id*. at 157. Claimant did not describe any trauma to the lumbar spine as a result of the toe injury; he did not describe any jarring or jolting of the lumbar spine as a result of the toe injury; he did not describe any falls to the ground as a result of the toe injury. *Id*.

Dr. Herskowitz testified as to the findings of his October 24, 2003 IME report. The clinical significance of his mental status examination was that Claimant was awake, alert, and oriented. *Id*. at 159. Nothing significantly abnormal was found, though Claimant was "somewhat spotty with the details of his past medical history." *Id*. at 160. A cranial nerve examination demonstrated an impairment with Claimant's right eye and poor papillary right reflex. *Id*. The remainder of the cranial nerve examination was normal. *Id*.

A motor examination demonstrated no weakness, though it was difficult to examine Claimant's left leg because of the pain Claimant was experiencing in that leg. *Id*. at 160-161. Dr. Herskowitz noticed no obvious atrophy, however. When Claimant tried to exert himself on the left leg resistance test, he said it was very painful, so Dr. Herskowitz did not pursue that test further. *Id*. at 161. Dr. Herskowitz testified that the neurological significance of the motor findings was that if there had been "an injury to a nerve, damage to the spine and the nerves that go to certain muscles, one will have weakness or atrophy or a decrease in size or bulk of that muscle." *Id*. Dr. Herkowitz did not detect any of these problems in Claimant's case. Rather, he stated that "when I could get [Claimant] to momentarily try and do some strength, I felt it was probably normal." *Id*.

Dr. Herskowitz also conducted a sensory examination, which tests for pin prick, touch, vibration, and different modalities that test perception. *Id*. He noted that often with diabetic patients, this test produces abnormal results. *Id*. Dr. Herskowitz testified that when he tested Claimant's entire left leg as compared to his right leg, "everything was abnormal." *Id*. Claimant "couldn't feel any modality. His vibration, his probe perception, which is basically moving a toe up and down with his eyes closed to see if he could perceive which direction it was going in or pin prick, he said everything on the left leg, the entire left leg wasn't as it was on the right leg." *Id*. at 161-162. Dr. Herskowitz testified as to these findings as follows:

> Well, that doesn't anatomically fit anything, and I didn't know whether there was some magnification of those symptoms because if somebody has

> pinched nerves in their legs, there's a certain strip or area, defined area in the leg in which it shows the abnormality. It's not globally the whole leg. It's impossible, unless you knock out every nerve that goes to the leg, but that would also affect motor findings, too. If somebody had a left leg that they feel very little, you would expect to find other things.
>
> So, I – I just really didn't feel – and it's subjective. That part of the exam, you're relying on the patient to tell you. So, I – I didn't give too much credence to that as being a positive for abnormal finding.
>
> Tr. 162.

Dr. Herskowitz also stated that the sensory findings were not in a dermatonal pattern. *Id*. He explained that a dermatonal pattern is when it is anatomic. *Id*. He further explained: "You trace a nerve root from the spine to where it finally goes and that's the area that you would find an abnormality, and I did not find a dermatonal pattern. So, it was just sort of globally diminished which didn't make sense anatomically." *Id*. at 162-163.

He also conducted a reflex examination, which demonstrated that Claimant's reflexes were diminished throughout. *Id*. at 163. He noted, however, that this was "very common in people who have diabetes" and that Claimant was "asymmetrical." *Id*.

With regard to how diabetes affects one's neurological condition, Dr. Herskowitz testified that it is very significant, since diabetes "causes degeneration or inflammation of the nerve endings." *Id*. Therefore, he stated, "frequently one has loss of sensation or abnormal perception of sensation. They may feel a burning sensation or they may not feel normal. Many times, if their foot's on the ground, they don't have good perception on where their foot is in space. So it can also cause weakness of affecting the nerve endings. So, it's very common." *Id*. at 163-164. Dr. Herskowitz also testified that, generally diabetic neuropathy is a progressive disease that "gets worse over time." *Id*. at 164.

Dr. Herskowitz also conducted a cerebellar examination, which basically tests coordination and muscle tone. *Id*. Claimant's limitations on this exam pertained only to his left; his lower extremities were normal. *Id*. Dr. Herskwitz also conducted a gaited station examination during which he basically watched Claimant walk. *Id*. at 164-165. He noted that Claimant had an antalgic gait, meaning that he was limping or had a painful-type gait. *Id*. at 165. Dr. Herskowitz stated that, "[Claimant] was using the cane, and basically as part of the exam, we get them to heel and toe off to test the various strengths, but he was limited because he said that he had pain performing these functions of his left leg." *Id*. He explained "hypersensitivity" or "hyperpathia" as follows:

> Well, hypersensitivity and hyperpathia are if you touch an area that's been damaged or is nerve damaged, they're super sensitive. They may feel something is uncomfortable where a person would feel it just as a normal touch, and sometimes it may be spontaneous, by just putting your sock on, it may be uncomfortable, and sometimes we see that, sometimes we don't with diabetic

neuropathy, and sometimes we see it after injuries, especially if there's an injured nerve.

Tr. 165.

Dr. Herskowitz testified that he did not find that Claimant had any "hypersensitivity" or "hyperpathia." *Id*. When questioned as to whether he felt that there was any symptom magnification on the part of Claimant, Dr. Herskowitz responded: "Well, I think in some parts perhaps, as I mentioned in my sensory exam, he may have been trying to magnify somewhat, but again meeting someone on one occasion, I try to give them the benefit of the doubt." *Id*. at 165-166.

Dr. Herskowitz testified that, based on his review of the medical records and the examination, his opinion was that Claimant did not suffer a permanent neurological impairment with respect to the March 22, 2001 accident. *Id*. at 166. He noted that Claimant had had multiple injuries and complaints prior to the accident, and that from his examination, he concluded that Claimant's injuries were "really confined to the big toe." *Id*. at 166-167. He further stated that he found it "very unusual that just a localized toe injury can cause this magnitude of complaints." *Id*. at 167. He also stated that "many times we see this many complaints of diabetics but without any other accidents going on, excluding the toe fracture." *Id*.

Dr. Herskowitz did not believe that Claimant was entitled to an impairment rating under the AMA Guidelines for neurological injury as a result of the accident. *Id*. He did not believe that Claimant had any neurological work restrictions as a result of the accident. *Id*. With regard to the etiology of Claimant's lumbar spine complaints, Dr. Herskowitz reiterated that he did not believe the accident was related in any way. *Id*. He further stated that "[Claimant] has had previous injuries to his back and had complaints in the records ongoing of back pain in the past and this may be a combination of injuries at his work and getting older." *Id*. With regard to the etiology of Claimant's pain in the lower extremities, Dr. Herskowitz maintained that these were "entirely subjective" complaints and that "people with diabetes can have complaints of pain, what we call neuralgia neuritis, but other than that, it's subjective [and could not be verified]." *Id*. at 168.

7. *Dr. Herbert Pardell*

Dr. Herbert Pardell testified on behalf of Claimant by way of deposition on October 28, 2003. He is board certified in internal medicine and has experience treating patients with diabetes for forty three (43) years. CX 2:4-5. He is not an endocrinologist. *Id*. at 23-24. At the time of his deposition, Dr. Pardell was still Claimant's treating physician with respect to diabetes. *Id*. at 6. Dr. Pardell first saw Claimant on May 15, 2001. *Id*. At that time, he noted a fifteen (15) year history of diabetes. CX 2:9. He also noted that Claimant was on oral hypoglycemics, one of them being Glucophage. *Id*. He further noted that Claimant never was on insulin, was not following a diet, and was taking no oral supplements other than Glucophage." *Id*. Claimant had claimed to otherwise be feeling well and had no other complaints. *Id*. His weight was constant. *Id*. Claimant informed Dr. Pardell that he had dropped a steel rod on his

toe two (2) months prior to the visit. *Id*. Also at the first visit, Dr. Pardell referred Claimant to Dr. Galitz for the toe problem.[20] *Id*.

With regard to Claimant's diabetic condition, Dr. Pardell testified that a medical record dated November 24, 2000 demonstrated that Claimant blood sugar was one hundred and twenty nine (129).[21] CX 2: 7. However, there was no indication whether this test was postprandial (i.e. after a meal) or after fasting, and therefore Dr. Pardell was unable to interpret the result. *Id*. In short, if the test had been conducted postprandial, it would demonstrate "good control" with respect to Claimant's blood sugar level; if it were conducted after fasting, it would be slightly elevated.[22] *Id*. Dr. Pardell also testified that on May 9, 2001, Claimant's blood sugar was two hundred and twenty one (221).[23] CX 2:8. While there was again no indication whether the test had been conducted postprandial or after fasting, Dr. Pardell indicated that generally two hundred and twenty one (221) indicates "poor control" and is elevated. *Id*. On cross examination, Dr. Pardell admitted that prior to his treating Claimant, there were instances "where [Claimant's] diabetes was out of control." CX 2: 21.

Based on his training, experience, and review of the current medical literature, Dr. Pardell stated that "[a]ny stressful condition, whether it is physical, emotional, chemical, environmental, whatever the condition is, will accentuate the diabetic status." CX 2: 10-11. He further stated: "In other words, any stressful situation, physical or mental, will increase the lack of control or disturb the control of a diabetic unless it's continually followed and adjusted. So an injury, an emotional upset, any environmental factors, many environmental factors will cause an effect on the status of the diabetic control." CX 2: 11. Dr. Pardell further testified that one's sugar going out of control can accelerate or aggravate the secondary effects of diabetes (e.g. vascular disease, retinal disease, kidney disease, heart disease). CX 2: 12. He stated that every organ system is affected by dyscontrol of diabetes. *Id*.

On cross examination, Dr. Pardell admitted that prior to his treating Claimant, there were instances "where [Claimant's] diabetes was out of control." CX 2: 21. He also admitted that a diabetic condition "can worsen for other reasons besides just having stress." *Id*. He indicated that some of the other reasons would be "improper medication or insufficient medication or patient's inability to follow diet." *Id*. Dr. Pardell clarified that improper diet refers to a patient who is not eating "a proper calorie-controlled diet." *Id*. Dr. Pardell was also questioned as to the

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[20] Dr. Pardell was later made aware of the fact that Claimant ended up seeing Dr. Galitz; he was also apprised of Claimant's condition with respect to the toe throughout his entire treatment from May 2001 to the present time. CX 2: 10. Dr. Pardell also knew that Claimant ended up having a surgical procedure that involved the "surgical insertion of a metal screw in to his interphalangeal joint to ankylose that bone" due to a "displaced and painful fracture in the IP joint." *Id*.

[21] Dr. Pardell indicated that he was not Claimant's physician at the time of this record. CX 2: 7. Still, he could interpret the record for purposes of the case. CX 2: 7.

[22] He indicated that, generally, under one hundred and fifty (150) after eating a meal or two meals demonstrates good control, while over one hundred and fifty (150) is not good control. CX 2: 8.

[23] Again, Dr. Pardell indicated that he was not Claimant's physician at the time of this record. CX 2: 7. Still, he could interpret the record for purposes of the case. CX 2: 7.

level of glucose plasma that is considered to be poor control for a diabetic. He responded that "for fasting blood sugar you like to see the sugar below 110, 110 or below. For postprandial blood sugar, which means say two hours after a meal, you like to see the blood sugar below 150." CX 2: 21-22. On cross examination, he was asked whether a glucose plasma reading of three hundred and fifteen (315) would be considered out of control, regardless of whether it was after fasting or after a meal. CX 2: 22. Dr. Pardell stated that it absolutely would indicate poor control. *Id*.

Dr. Pardell stated that Claimant was currently on a calorie-restricted diet with respect to his diabetic condition. CX 2: 24. He was also on oral hyopglycemics, including Glucophage, Glipizide, and Avandia. *Id*. When Dr. Pardell first saw Claimant, however, he was not on Avandia.[24] *Id*. Since Claimant started taking Avandia, his last blood sugar postprandial was one hundred and twenty seven (127), which is very good control. CX 2: 26. His last hemoglobin A1C, however, was still not where Dr. Pardell thought it should be.[25] *Id*.

Although at his deposition, Dr. Pardell could not recall Claimant's having shown signs of depression, Dr. Pardell stated that his notes indicated Claimant had been feeling depressed on April 29, 2002. *Id*. at 16. He also noted another "subjective complaint of depression" from Claimant on May 13, 2002. *Id*. at 15. At that time, Dr. Pardell referred Claimant to a psychiatrist. *Id*.

8. *Dr. Martin S. Cohen*

Dr. Martin Cohen testified on behalf of Employer by way of deposition on November 3, 2003. He specializes in endocrinology and internal medicine and is board certified in endocrinology, metabolism, and internal medicine. EX 22:5. Dr. Cohen examined Claimant on October 27, 2003. *Id*. at 7. At that time, Claimant told Dr. Cohen that he had suffered from diabetes for fifteen (15) years and that his blood sugar had been "up and down in the past." *Id*. at 9. While he could not "quantitate from the information" provided by Claimant "how up and down it was," he noted that Claimant "was checking at home with an Accu Check Advantage machine" on a daily basis. *Id*. According to Claimant, "his sugars [at the current time] were averaging between 140 and 150 milligrams percent." *Id*. Dr. Cohen testified that this represented "fair to good control." *Id*.

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[24] Dr. Pardell explained that Avandia is a more recent approach to controlling diabetics on oral hypoglycemics. CX 2: 24. Specifically, it increases the cell sensitivity to the insulin that Claimant has in his system. *Id*. Avandia is helpful because "it increases the insulin action, which is to burn the sugar and deposit it rather than not be effective." *Id*. Dr. Pardell defined "Type II" diabetics as diabetics who have insulin in their system but are not utilizing it properly. CX 2: 25. He further testified that Avandia "desensitizes" Type II diabetics, who have a resistance to the insulin that is already in their system, so that they will become sensitive to the insulin. CX 2: 24-25.

[25] Dr. Pardell explained that hemoglobin A1C is a marker of insulin – of diabetes control. CX 2: 26. Claimant had been up to eleven (11) prior to the year of the deposition, and at the time of the deposition he was at 7.1, which is close to where Dr. Pardell thought it should be (though ideally it would be below six (6)). Dr. Pardell explained that a hemoglobin A1C of eleven (11) meant that Claimant was not utilizing his sugar properly. CX 2: 26. He indicated that with the use of Avandia, he believed Claimant's hemoglobin A1C would be below six (6). CX 2: 27.

Dr. Cohen stated that "at the present point in time, [Claimant] seems to be maintaining what I would consider to be very, very good control." *Id*. at 11. Claimant's weight has been constant for the past few months. *Id*. Claimant told Dr. Cohen that he had a "rare reaction, that is a low blood sugar." *Id*. He also informed Dr. Cohen that, since the time of the accident, his blood sugar had been high. *Id*. at 12. Claimant advised that he was "status post bilateral laser treatment to the eye" from which Dr. Cohen gleaned that Claimant had diabetic retinopathy "greater than a year ago." *Id*. Claimant had a right-detached retina and had markedly decreased vision in his right eye. *Id*. He later advised Dr. Cohen that he could "hardly see from that right eye, and it wasn't functioning too well, but he could manage from the left eye, where he also had retinopathy." *Id*.

Dr. Cohen testified that Claimant's description of his toe surgery was that it involved the left first toe with the placement of a pin and then removal of a pin. *Id*. at 13. Claimant complained of paresthesias of his feet, which are electrical-like feelings, usually associated with diabetic neuropathy. *Id*. Claimant also purported to have pain in his back and legs, which kept him up at night. *Id*. at 13-14. Dr. Cohen testified that Claimant reported having "fallen twice in the past two weeks … lost his balance and hit his head … and was having headaches for the past week or so." *Id*. at 14. Claimant told Dr. Cohen that he had last worked on March 22, 2001. *Id*. at 15. He had been a longshoreman. *Id*. A steel bar lashed on his left first toe. *Id*. He has never smoked and has no alcohol intake, no substance abuse, and no known allergies. *Id*. Dr. Cohen testified that Claimant had very little insight into his diabetic diet. *Id*. Dr. Cohen testified that Claimant reported being on various medications, including Glucophage, Prinivil, Glipizide, Avandia, Sonata, Hydrocodone, one to two a day (Claimant did not know the amounts of the other medicines). *Id*. at 14. Claimant was using a cane. *Id*. He denied any prostate problems. *Id*. No bowel disease. *Id*. His first toe still hurt, and it radiated to his back. *Id*. Claimant told Dr. Cohen that his mother had been a diabetic. *Id*.

Dr. Cohen performed a physical examination on Claimant during which he conducted a direct funduscopic exam, which looks in the retina of the eyes. *Id*. at 16. The right eye showed extensive retinopathy with a lot of old scarring. *Id*. This "went along with the history that he had very little, useless vision of that right eye." *Id*. Dr. Cohen stated that he could not tell what was going on with the left eye. *Id*.

With respect to the history of Claimant's diabetic condition, Dr. Cohen testified that "he really wasn't good controlled diabetic going back, way, way back. With A-1 Cs that were very high, with sugars of the 300." *Id*. at 18-19. Dr. Cohen stated that Claimant also suffered from complications of diabetes, such as diabetic retinopathy and neuropathy. *Id*. at 19. He specified that Claimant was a poorly controlled diabetic even at the time of the original accident in 1988. *Id*. He testified that Claimant's A-1 C in the three (3) months prior to the March 22, 2001 accident was 11.6 and that "an 11.6 is a little less than a 300 average, which is terrible." *Id*. at 21.

Based on his review of the records and physical examination of Claimant, Dr. Cohen's diagnosis was that Claimant had been a Type II diabetic for fifteen (15) years, "way before the accident occurred," and that "the accident had nothing to do with the causation of his diabetes." *Id*. He also noted that Claimant had sustained "two severe accidents" and that he had

"hypertension" defined as "the elevated blood pressure out of control." *Id*. at 21-22. Claimant also suffered from "decreased vision of the right eye" which was "diabetic proliferative retinopathy" and "probably had significant retinopathy of the left eye" though it could not be visualized. *Id*. at 22. He had a systolic murmur, which Dr. Cohen opined warranted evaluation with stress testing due to Claimant's history of severe hypertension and thick ventricle. *Id*. Dr. Cohen added that, because "80 percent of diabetics will die of heart attacks and strokes," such problems must be closely monitored. *Id*. at 23.

Dr. Cohen did not believe that Claimant suffered a permanent injury from the March 22, 2001 accident as it applies to endocrinology. *Id*. at 23. He stated that:

> There was no medical basis of why an injury to the foot, for example, would give someone diabetes or cause high blood pressure. We are talking about very frequent diseases in our population that, you know, unless someone gets a major pancreatitis, which is inflammation of the pancreas, from a board or a steering wheel hitting your abdomen, and actually giving direct trauma to the pancreas, there no way I can tie this accident into the causation of his diabetes or high blood pressure."

Id. at 24.

When questioned, however, as to whether the March 22, 2001 accident caused any aggravation of Claimant's diabetic condition, Dr. Cohen opined that this was a "trickier" issue. *Id*. He stated that:

> [T]he amount of insulin a pancreas has to make to keep your sugar … normal at 100 is related to what goes on in the environment around you. It's a big factor … If you gain weight, for example, you need more insulin to be produced to control your blood sugar than someone who is thin. If you are in pain on a daily basis, you need more insulin to control your blood sugar from that healthy pancreas to keep it at 100. If you're a diabetic, and you cannot make that additional insulin, you may require more medication to control your diabetes. But once again, it did not give you the diabetes. It did not cause the diabetes. But it may make the diabetes somewhat more difficult to control because more insulin may be needed, let's say, by injection, or more pills may be needed to control the sugar because of the increased need.
>
> If the pain goes away, then the insulin requirement, in all probability, will be lower. We commonly see this in our diabetics, for example, on the way to the office, will get into a fender-bender accident. They are not hurt in any way. They are just emotionally upset. They need more insulin for a couple of days to handle that. Then it goes away. They are back to where they were. But stresses increase the need of insulin.
>
> Stress also increases the need for blood pressure medicine. You take away stress from people, send them on a vacation, a free vacation somewhere, they don't need

> their blood pressure pills as much as they did when they are at work in Miami. So stress plays an important role. Stress in this man is his inactivity, his probable loss of income, and the pain that he has. And it probably exacerbates somewhat his problems.

Id. at 24-26.

When questioned as to what Claimant would be required to do to remedy any "exacerbation" of his problems, Dr. Cohen stated that he "may need more medication." *Id*. at 26. Dr. Cohen reiterated that Claimant is a Type II diabetic, that he has had diabetes for about 15 or 16 years, and that eventually he will require insulin. *Id*. He further stated that "[t]he end result, if [Claimant] lives to 100, he will be on insulin." Dr. Cohen pointed out that "[a]ll Type II diabetics will eventually require insulin." *Id*. The fact that Claimant "is very inactive and he is in chronic pain, assuming that to be true, will [mean that] instead of [at] age 100 needing insulin, maybe at age 95 he will … It may occur a little earlier. If he can be controlled on pills, it may take an extra pill … But the accident did not give him these problems." *Id*. at 26-27. Dr. Cohen testified that, while Claimant would be able to keep good control for the time being by taking his medications as prescribed, "there will be a point in time when [Claimant] will fail on [the] triple therapy [i.e. the Avandia, Glucophage, and Glipizide]." *Id*. at 29-30. He further stated that Claimant was "maxed out on medicines now" and that "he is pretty close to needing insulin now" though he did not "feel the accident caused that." *Id*. at 30.

Dr. Cohen stated that both diabetic neuropathy and diabetic retinopathy had nothing to do with the March 22, 2001. *Id*. at 30-31. Rather, they were both "complications of long-standing diabetes, usually more severe, the worse the control." *Id*. at 31. With regard to Claimant's control before the accident, Dr. Cohen stated that there were "a lot of markedly out-of-control" instances. *Id*. Although he could not state with certainty the condition of Claimant's control since the accident, Dr. Cohen had a feeling that it was "much better." *Id*. at 31-32. At the time he examined Claimant, Dr. Cohen's opinion with respect to Claimant's diabetic condition was that he had "extensive retinopathy" and "moderate neuropathy." *Id*. at 32. Claimant's control seemed "reasonably good" and Dr. Cohen was satisfied that Claimant was "getting good care now." *Id*. Dr. Cohen testified that Claimant's control at the time of his examination was "definitely a lot better" than it was before the March 22, 2001 accident. *Id*. at 33. Specifically, he contrasted the average sugar levels of approximately 280 or 290 before the accident with the average sugar levels of approximately 135 or 140 at the time of his examination. *Id*.

On cross examination, Dr. Cohen explained that out-of-control diabetics have "blood sugars that are good and bad" such that "a single blood sugar reading is really not germane. It's a meaningless piece of information." *Id*. at 37. Neither a single blood sugar reading that is very high nor a single blood sugar level that is very low would be dispositive of one's overall control. *Id*. On cross examination, he admitted that a serious back injury, involving a herniated disc pressing on a nerve for example, could cause symptoms similar to a neuropathy into the legs and feet. *Id*. at 39-40. However, he specified that Claimant's reflexes were absent on both sides and that would take a "midline herniated disc" and a "lower lumbar" to cause such symptoms. *Id*. at 40. Dr. Cohen then admitted that one of Claimant's chief complaints was pain in the low back. *Id*.

On cross examination, Dr. Cohen stated that, from what he could recall, Claimant was only on Glucophage and Glipizide before the March 22, 2001 accident and did not begin taking the third medication, Avandia, until after the accident. *Id*. at 41. He admitted that the chronic pain, surgery, and stress undergone by Claimant after the accident could have possibly played a role in Claimant's needing to start taking the third medication, Avandia. *Id*. Finally, Dr. Cohen stated that the "fundamental control of any good diabetic comes from the diet." *Id*. at 42.

9. *Dr. Harry Hamburger*

Dr. Harry Hamburger testified on behalf of Claimant by way of deposition on October 15, 2003. He is board certified in ophthalmology and has fellowship training in neuro-ophthalmology. CX 3:3. Dr. Hamburger saw Claimant on October 13, 2003 at which time Claimant advised that prior to the accident he had been a diabetic under good control on oral medications, but that his blood sugar became uncontrollable following the accident, reaching levels as high as three hundred (300). *Id*. at 5-6. Claimant had told Dr. Hamburger that sometime in July 2001, he noticed the vision in his right eye becoming tilted and gradually fading. *Id*. at 6. Claimant was seen at Bascom Palmer and was ultimately found to have proliferative retinopathy in his right eye from the diabetes with tractional retinal detachment. *Id*. On September 19, 2001, Claimant underwent treatment on his right eye. *Id*. at 6-7. Claimant also required therapy on his left eye for proliferative diabetic retinopathy and additional laser treatment on his right eye. *Id*. Despite all three (3) therapies, Claimant lost what was considered useful vision in both eyes. *Id*. at 7.

Dr. Hamburger performed a physical examination of Claimant, which revealed no light perception in the right eye (i.e. Claimant could see nothing, not even light, in the right eye). *Id*. at 8. In the left eye, Claimant was 20/400, meaning he could see "the big E on the eye chart." *Id*. In the left eye with correction, Claimant could see the "20/70 line with difficulty." *Id*. Dr. Hamburger recommended tight control of Claimant's blood sugar in the future and eye examinations every three (3) to four (4) months to monitor mainly the left eye. *Id*. at 10. Claimant's left eye would not improve but could get worse and require additional therapy. *Id*.

He testified that multiple studies demonstrate that when blood sugar goes out of control, the risk of developing retinopathy or bleeding in the eye increases. *Id*. at 12. By contrast, when blood sugar is carefully controlled, there is a marked decease in the risk of these problems. *Id*. He further noted that physical stress, illness and surgery all affect blood sugar, and that the stress of surgery exacerbates the metabolic abnormalities of diabetes mellitus. *Id*. According to Dr. Hamburger, even the minimal stress of cataract surgery has been shown to increase the risk of proliferative diabetic retinopathy in the eyes. *Id*. at 12-13. Thus, he advised that patients must be counseled that simply the stress of going through cataract surgery can take an eye that has diabetic retinopathy and cause proliferative diabetic retinopathy to occur following surgery. *Id*. In other words, patients must be apprised of the fact that their diabetes may progress following what would be considered just minor eye surgery in a normal patient. *Id*. at 13.

Dr. Hamburger testified that it is possible for diabetic patients to go from having no retinopathy (or minimal retinopathy) to developing severe retinopathy in approximately six (6) months. *Id*. at 15-16. He opined that it was possible for Claimant to have developed severe diabetic retinopathy in the six (6) month period that elapsed between the March 22, 2001 accident and the onset of Claimant's severe diabetic retinopathy in September 2001. *Id*. at 16. Dr. Hamburger stated that Claimant "could go from minimal background diabetic retinopathy with a few little dot hemorrhages scattered around which was not really affecting his vision in any way to this type of proliferative diabetic retinopathy if his blood sugar was high and out of control." *Id*. At the same time, Dr. Hamburger testified that, while six months would have been sufficient time for diabetic retinopathy to develop, it could have started developing before March 22, 2001. *Id*. at 31. There could have been early proliferative stages developing prior to March 22, 2001, and if Claimant's blood sugar when out of control after that, the proliferative changes would have rapidly accelerated and become worse and more aggressive. *Id*. Although he could not identify when the whole process started, Dr. Hamburger opined that Claimant "probably had some background retinopathy changes with mild bleeding for a long time." *Id*.

Ultimately, Dr. Hamburger stated that he would have to defer to diabetes specialists on the question of what precisely caused Claimant's diabetes to become out of control. *Id*. at 18. In addition, he admitted that he had not seen Claimant's long-term history of blood sugar control before the accident, and that such an analysis was more within the realm of an endocrinologist. *Id*. at 26. Further, Dr. Hamburger testified that if blood sugar is not controlled and diabetic retinopathy goes untreated, it can be a progressive disease but is not always a progressive disease. *Id*. at 28. He testified to the effect that it would be difficult to precisely pinpoint in time the stages of Claimant's problem. *Id*. at 30. He could testify with certainty only that Claimant was proliferative when he was seen by Dr. Loo in September 2001 and that his vision problems began sometime in July 2001. *Id*.

Dr. Hamburger calculated a total body impairment rating of thirty seven (37) percent based on Claimant's visual acuity.[26] *Id*. at 10. Regarding whether Claimant would be able to return to work as a longshoreman, Dr. Hamburger testified that he would not be able to "climb, drive pieces of equipment like forklifts and tractor trailers." *Id*. at 18. Moreover, he stated that Claimant "can't drive a vehicle of any kind, can't work with power tools, can't climb at heights because he has no depth perception, can't read for extended periods of time because of the poor vision in his left eye that remains." *Id*. Claimant would be precluded from any kind of employment that would require binocular vision or depth perception. *Id*. at 19. He would also be "precluded from any type of employment that would involve extended use of his eyes for reading or near work." *Id*. Dr. Hamburger suggested that Claimant could perhaps "answer a phone or do some type of alternative employment" and that, while he should not be sitting at home, he could not go back to the employment he was doing before. *Id*. at 18-19.

10. *Dr. Henry L. Trattler*

[26] This figure assumed no light perception in the right eye and 20/70 in the left eye. If the left eye were to deteriorate to 20/400, then Claimant's rating would increase to fifty six (56) percent. CX 3:10-11.

Dr. Henry Trattler testified on behalf of Employer by way of deposition on November 5, 2003. He is a board certified ophthalmologist. EX 21:3. Dr. Trattler stated that Claimant had a history of diabetes for over fifteen (15) years and that his medical records from different hospitalizations and clinics revealed some fluctuations in Claimant's blood sugar over the years. *Id*. at 9. Claimant basically had long-standing adult diabetes, known as Type II diabetes. *Id*. Dr. Trattler also observed that, because Claimant's mother was a diabetic and he had a family history of diabetes and hypertension, Claimant was "in a situation where he was predisposed to these things." *Id*. at 48. Dr. Trattler testified that Claimant's records from Bascom Palmer date back to 1996, when Claimant was first seen and described as having diabetic retinopathy. *Id*. at 10. Specifically, the record from December 23, 1996, reflected "DM" (i.e. diabetes mellitus) and "mild BDR" (i.e. background diabetic retinopathy). *Id*. The record stated that Claimant had diabetes in the retina. *Id*. at 10-11.

Claimant's next significant medical record, dated August 21, 2000, marked a time when he was seen at the triage clinic by Dr. Evelyn Baker. *Id*. at 12. In the record, Dr. Baker stated that Claimant had "a lot of changes in the retina, which are typical for progressive diabetic retinopathy." *Id*. Dr. Trattler explained that this meant Claimant had bleeding on the surface of the retina, underneath the gel of the retina, and neovascular membranes were starting in areas of edema. *Id*. at 12-13. Dr. Trattler stated that these were all "typical findings of advancing diabetic retinopathy" meaning the type of diabetic retinopathy that is progressing from the background stage, which simply includes some surface bleeding, to more severe changes. *Id*. at 13. The August 21, 2000 medical record showed that Claimant was also seen by Dr. Bends, who recommended that Claimant undergo laser therapy[27] to stop the progression of the diabetes or the diabetic changes in the eye itself. *Id*.

In explaining what his prognosis would have been at the time of the August 21, 2000 medical record, Dr. Trattler stated that if a diabetic is left alone with no treatment, the chance of going blind when they are developing these types of changes is seventy five (75) percent. *Id*. at 14-15. He continued that there is a twenty five (25) percent chance that the patient may maintain vision. *Id*. However, if the patient is treated with panretinal photocoagulation (PRP), the risk of blindness is reduced to only twenty five (25) percent. *Id*. In other words, seventy five (75) percent of patients will stabilize their diabetes, and it will not get worse, and twenty five (25) percent will continue to get worse in spite of this therapy. *Id*.

Dr. Trattler testified that Claimant did not undergo the follow-up treatment described above at the time of the August 21, 2000 medical record. *Id*. at 15. However, he did undergo the treatment after he developed the retinal detachment (traction detachment) in September 2001. *Id*. Panretinal photocoagulation was later performed on his left eye. *Id*. Although the procedure had been recommended by Dr. Baker in August 2000, the treatment for Claimant's traction retinal detachment, which was diabetic in nature, was actually performed in September 2001. *Id*.

[27] Dr. Trattler explained that laser therapy is one of the methods that will slow down or sometimes stop the progression of diabetic retinopathy. Laser therapy is the standard therapy for this type of condition. EX 21: 13-14. Specifically, it is an "Argon laser" or thermal laser that actually coagulates or burns the retina. EX 21:14. It destroys some of the retina cells, but it decreases the amount of nutrition that the retina needs. *Id*. Thus, it seems to stop the progression of these new vessels from growing. *Id*.

Thus, there was about a thirteen (13) month interval between the time that the procedure was recommended and the time that the treatment was actually performed. *Id*.

With regard to the importance of immediate treatment, Dr. Trattler stated that when there is ischemia (i.e. lack of circulation to the tissues), the tissues put out a stimulant that causes new blood vessels, called neovascular vessels or neovascular membranes, to grow and to try to heal the eye. *Id*. at 16. When there is proliferation of these neovascular membranes, they can bleed on their own or cause traction detachments, which is what happened to Claimant. *Id*. Dr. Trattler testified that going from background retinopathy to proliferative retinopathy "is a very bad change in the eye" and has a "very poor prognosis." *Id*. When this seems to be occurring or it is speculated that this is going to occur, it must be treated aggressively with laser. *Id*.

Dr. Trattler testified that when Claimant presented in September 2001, he had lost vision in his right eye because his retina had been pulled off the back wall of the eye from this traction. *Id*. Claimant had complete retinal detachment. *Id*. At that time, Dr. Loo performed a complex operation of removing the scar tissue that was pulling the retina off, which is known as a pars plana vitrectomy. *Id*. at 17. He also performed a photocoagulation of the retina, that is to laser it. *Id*. He then took out the fluid and put in silicon oil to push the retina back and exchange that with air. *Id*. Dr. Loo "basically performed a very complex operation to try to get the retina to reattach in that right eye. He later performed PRP laser treatment to the left eye to try to prevent that from "going downhill." *Id*.

Dr. Trattler testified that when he asked Claimant who was taking care of his eyes, Claimant responded that he had not seen any doctors except Dr. Hamburger and that he was not going back to Bascom Palmer. *Id*. Dr. Trattler stated that he was not aware of who had been following up on Claimant's diabetic retinopathy. *Id*. He further testified that Claimant told him that "he [had undergone] major surgery [at Bascom Palmer]" and that "before they did the laser surgery in his left eye, his vision seemed to be getting worse but that it seemed to get a little better recently." *Id*. at 17-18. Dr. Trattler testified that at the time he saw Claimant, the chief eye complaints were that he could not see out of his right eye; that he had gone blind; and that he was having difficulty with vision of his left eye but that he felt that it had stabilized. *Id*. at 18.

At the time of his visit with Claimant, Dr. Trattler performed a complete ophthalmic examination and took photographs of the retina. *Id*. In Claimant's right eye, the photographs revealed scar tissue coming off the optic nerve, dense black scarring on the retina where the photo coagulation was performed, and some paleness to the optic nerve itself, and basically sclerosis or thinning of all the major arterial vessels coming in. *Id*. at 19. According to Dr. Trattler, this would explain the cause of [Claimant's] loss of complete vision in his right eye. *Id*. He further stated that Claimant "has no light perception" and that "he doesn't see anything." *Id*. Dr. Trattler believed that this was valid as he checked Claimant for malingering and found that "he really is blind in his right eye completely." *Id*.

With regard to Claimant's left eye, Dr. Trattler testified that the nerve was a little pinker [and] had a little better circulation. *Id*. at 19-20. He stated that "one can see areas of darkness where the laser was peripherally treated, but again, there is a white scar tissue or proliferation coming off the back of the eye." *Id*. at 20. He continued "so this is the kind of proliferation or

scar tissue that can pull the retina off." *Id*. Dr. Trattler noted that when he examined Claimant clinically, it "looked like there was some fluid underneath the retina, under the vessels, about the 5:00 position, [and that] he had a little retinal edema around that area." *Id*. In addition, there was some scar tissue in the macular, which is the "center of our eyesight" and "what we read with." *Id*. The macula "looked like it had some superficial scar tissue or retinal membrane there, and that could account for his decreased central vision in the left eye." *Id*. Dr. Trattler testified that with regard to visual acuity, the best that it could be corrected was to 20/80 with glasses. *Id*. He further stated: "When we refracted [Claimant], he got about the same, but a superpinhole vision said his vision might be as good as 20/50, but neither one of those eyesights are particularly good." *Id*.

Dr. Trattler testified that at the conclusion of his examination, his impression was that Claimant basically had advanced diabetic retinopathy, that he was blind in his right eye, and that he had had the right lens removed so that he was surgically aphakic. *Id*. at 21. He further found that even a pair of glasses (Claimant would require a plus-12 glass over the right eye) did not improve his vision because he could not see light. *Id*. Dr. Trattler opined that Claimant had irreversible blindness in his right eye. *Id*. Claimant's left eye had decreased vision at 20/80. *Id*. He had scarred peripheral vision from the laser therapy and the diabetes, and Claimant was still at risk for going blind completely in his left eye if he failed to have further follow-up care and treatment. *Id*. at 21-22.

Dr. Trattler next stated his opinion as to whether any of his impressions regarding Claimant's eyesight were related to Claimant's toe injury on March 22, 2001. *Id*. at 24. He opined that Claimant had severe diabetes involving the vascular system, especially in his eye, and that his situation might have been improved if he had had earlier intervention with laser. *Id*. However, Claimant did not have this earlier intervention, and the changes he subsequently underwent reflect changes that are seen in diabetics who go untreated (i.e traction retinal detachment and proliferative retinal diabetic changes). *Id*. Dr. Trattler testified:

> An accident itself I think has no direct bearing on it. His diabetes control – we tell patients they have to try to control the diabetes as well as they can. At this stage of his retinal vascular disease, I think the control is not going to be the major issue. It's going to be controlling the ischemia and the proliferation with laser that is going to stop the progress of the diabetic retinopathy."

Id. at 24-25.

Dr. Trattler further stated that "even with the most perfect of treatments that we have available at our disposal, we still have 25 percent of the patients who will go on and go blind." *Id*. at 25. On cross examination, Dr. Trattler did not agree that the March 22, 2001 accident or Claimant's subsequent surgery accelerated the proliferative diabetic retinopathy because "it was based on 15 years of abnormal blood vessels damaged from this disease that had [already been going on] for a decade and a half." *Id*. at 31. He further stated that by August 2000, Claimant

"was already getting in major trouble"[28] and that "intervention at that time could have stopped him from getting the traction retinal detachment, which he presented with by the summer of 2001." *Id*. at 29.

In sum, Dr. Trattler opined that, based on his review of the medical records and his independent medical evaluation (IME) of Claimant, the etiology of the findings in the IME are all related to his diabetes. *Id*. at 25. He further opined that Claimant could be held at this level of vision for quite awhile, as long as he doesn't develop any evidence of new neovascularization (meaning as long as the new blood vessels do not develop on the surface of the optic nerve or on the surface of the retina or on the surface of the iris, causing secondary glaucoma). *Id*. at 25-26. The only way to know that is for him to have very careful systematic follow-up. *Id*.

Dr. Trattler stated that if Claimant were under his care, he would require that Claimant be seen at least three (3) times a year, every four (4) months. *Id*. at 26. He would further require that Claimant have fluorescent angiography performed, which was not done, and other testing to follow his level of vision. *Id*. Dr. Trattler opined that Claimant was visually handicapped and could not have a Florida driver's license. *Id*. He further stated that Claimant "would probably have difficulty working around any kind of dangerous equipment because … when you do the photocoagulation, you take away the side vision, and he has had photocoagulation of his left eye all around. [H]is side vision would be limited." *Id*. Dr. Trattler opined that Claimant might be able to work in "some kind of office job" but that "he really should not be around big, heavy equipment or machinery." *Id*.

11. *Dr. Bernardo Garcia-Grande*

Dr. Bernardo Garcia-Grande testified on behalf of Claimant by way of deposition on October 22, 2003. He is board certified in psychiatry. CX 5:3. He has had experience treating patients with psychiatric problems resulting from work-related injuries. *Id*. at 4. The evaluations undertaken by Dr. Garcia-Grande were at the referral of Claimant's attorney. Dr. Garcia-Grande first saw Claimant on June 4, 2002. *Id*. at 5. Dr. Garcia-Grande testified at length with regard to the symptoms that Claimant had been experiencing. Specifically, Claimant had described being unable to sleep at night, becoming depressed, losing weight, and losing his appetite. *Id*. at 6-7. Claimant felt no desire to do anything and no pleasurable activities would motivate him. *Id*. Claimant's wife advised that she had "to push him to take a shower [and that Claimant] stares out of the window, cries easily, and feels helpless." *Id*. at 7. Dr. Garcia-Grande testified that Claimant placed his level of pain at "a level of nine on a scale of zero to ten." *Id*. He had been taking pain medication, which helped the pain decrease somewhat. *Id*. However, as soon as Claimant ceased taking the medication or as soon as it would wear off, Claimant's pain would "go back up again." *Id*.

[28] Specifically, by August 2000, Claimant already had pre-proliferative changes. EX 21:30. He already had bleeding outside of the retina into the gelatin or subhyaloid space and he did not have any therapy for this for another year. *Id*.

Dr. Garcia-Grande testified that Claimant had provided him with a synopsis of his medical history, particularly his recent problems, and indicated that he "feels his life has changed completely." *Id*. at 7-8. Although Claimant stated that he "used to be a happy person, now he just feels sad all the time." *Id*. at 8. Dr. Garcia-Grande noted that Claimant was crying while relaying this. *Id*. He also noted that there was nothing remarkable, psychiatrically, in Claimant's past medical history. *Id*. Claimant specifically denied having ever been to a psychiatrist before or having any psychiatric treatment. *Id*. at 9.

Dr. Garcia-Grande performed a mental status examination on June 4, 2002, which revealed that Claimant "appeared to be very depressed." *Id*. Specifically, Claimant's speech was soft in tone and slow in rate, which Dr. Garcia-Grande testified is typical of people with depression. *Id*. at 9-10. Claimant's affect was flat, meaning there was very little facial expression. *Id*. He had a very low self-image and self-worth. *Id*. He cried during the interview. *Id*. Other than that, however, the rest of the exam was negative, meaning that Claimant was oriented, knew where he was, knew his name, and knew the date; there were no hallucinations and nothing psychotic. *Id*. Claimant did not appear to be a danger to himself and was not acutely suicidal, though he did demonstrate symptoms of severe type of depression. *Id*.

Dr. Garcia-Grande testified that Claimant also had a problem with short attention span. *Id*. at 10. He testified that during the examination, Claimant had some difficulty following the questions, which was probably due to the depression. *Id*. Dr. Garcia-Grande's diagnostic impression, according to the diagnostic and statistical manual of the American Psychiatry Association, was that on Axis I, which evaluates major psychiatric conditions, Claimant had a severe depressive disorder. *Id*. at 10-11. On Axis III, which relates to any major significant physical conditions that concern or worry an individual, Dr. Garcia-Grande noted depression with regard to left foot and back pain. *Id*. On Axis IV, which relates to any significant problems that an individual is facing, Dr. Garcia-Grande identified Claimant's occupational problem, i.e. that he had been working for twenty four (24) years as a longshoreman and that he was now unable to do so. *Id*. Finally, on Axis V, which encompasses a global assessment of functioning (GAF) and measures a person's functionality on a scale from zero (0) to one hundred (100), Dr. Garcia-Grande rated Claimant at a fifty (50), which connotes serious symptoms. *Id*.

Dr. Garcia-Grande opined that Claimant was very depressed and would benefit from immediate psychiatric care. *Id*. at 11. He did not specify what type of treatment but that he would need antidepressant medications and psychotherapy to help him with his self-image and self-esteem.[29] *Id*. He opined that the cause of Claimant's major depression was "the constant chronic pain [from the injuries of the March 2001 accident] that he has that never leaves him." *Id*. Dr. Garcia-Grande added that the pain would not allow Claimant to sleep and contributed to his "inability to have a rested night." *Id*. at 12.

After the initial visit with Claimant on June 4, 2002, Dr. Garcia-Grande saw the Claimant again on September 10, 2003 for a re-evaluation. *Id*. at 12. Claimant had not received any of the treatment that Dr. Garcia-Grande had recommended previously. *Id*. At the re-evaluation, both Claimant and his wife were interviewed. *Id*. at 13. According to Claimant's wife, he had

[29] Dr. Garcia-Grande mentioned that this was not specified in his medical report where he simply recommended psychiatric care. CX 5: 11.

become irritable and restless and continued to have difficulty sleeping, although his primary care physician had prescribed sleep medication, Sonata. *Id*. Moreover, Claimant spent most of his time at home, continued to use a cane to walk, and was afraid of falling. *Id*. His wife also testified that Claimant "cries at night alone because he doesn't want her to see him crying. He has no social life, basically watches TV, but quickly loses interest in whatever show he is watching." *Id*. at 13-14. Claimant's wife also mentioned the issue of diabetes and the fact that Claimant's condition had deteriorated after the accident and after the surgery, and that his eyesight had deteriorated significantly. *Id*. at 14. He was not able to read a newspaper or magazine. *Id*. Claimant's wife also described him as being very depressed at home. *Id*. He paces back and forth at home, ruminating about his problems. *Id*. He is always talking about the things he cannot do because of his physical condition, complains of pain, as he was before, complains also now of headache. *Id*. He describes his pain in his back and numbness in his left foot. *Id*.

At the re-evaluation, Dr. Garcia-Grande once again performed a mental status examination. *Id*. The examination revealed a very depressed person. Dr. Garcia-Grande testified:

> As before, the tone of [Claimant's] voice was soft and he spoke at a slow rate. The affect was restricted with staring episodes. Basically the same way he presented last time. Mood is significantly depressed with a sense of helplessness and hopelessness and frustration. He has psychomotor retardation, meaning he walks slowly, he speaks slowly, he moves slowly. Those are all signs of depression. Memory appeared to be somewhat fair for recent events. He had some difficulty recalling certain things, but for remote events he was fine. Again, the lack of attention, concentration, I could see that during the interview.

Id. at 14-15.

In addition to these findings, Dr. Garcia-Grande indicated that Claimant seemed "somewhat deteriorated" and a little worse than the first time he saw him. *Id*. at 15. He appeared to have more difficulty with memory and concentration. *Id*. Again, Dr. Garcia-Grande recommended psychiatric treatment but did not specify what type, though stated it would be "something of the nature of antidepressant medications, psychotherapy." *Id*. He added, however, that, because of the chronicity of the symptoms and the length of time he had been depressed and experiencing chronic pain, results of therapy would probably not be very positive. *Id*. This was because Claimant's mind was "already fixed in this chronic state of depression and it's very difficult sometimes to improve a person's condition when they are so chronically deteriorated." *Id*. at 16. Dr. Garcia-Grande testified that the sooner one treats a psychiatric condition, the better, and that the longer one waits to seek treatment, the worse the prognosis gets. *Id*. at 18. However, he also testified that it would be too speculative to assume that Claimant's condition deteriorated because he did not receive any psychiatric care. *Id*. at 17.

Dr. Garcia-Grande testified that from a psychiatric standpoint, due to the severity of Claimant's condition, he did not think that he was capable of working in any capacity as of September 10, 2003. *Id*. at 16. He had similarly opined that Claimant was not capable of

working due to the severity of his depression at the first consultation on June 4, 2002. *Id*. With regard to which aspects of his severe depression would preclude Claimant from working, Dr. Garcia-Grande testified that Claimant's severe depressive mood "does not allow him to concentrate or stay attentive to any task that he would perform in any kind of work. *Id*. at 17. He is focused on pain and is constantly worrying about his pain, the future, and crying spells." *Id*.

With regard to maximum medical improvement, Dr. Garcia-Grande testified that if Claimant had not since received treatment and did not receive any treatment in the future, then he had reached maximum medical improvement. *Id*. at 19. Nevertheless, the doctor still recommended therapy or treatment; if Claimant were able to receive some treatment, then he would not yet be at maximum medical improvement. *Id*. He further testified that, based upon the condition diagnosed on September 10, 2003, Claimant was left with a permanent psychiatric impairment. *Id*.

With regard to a rating concerning the level of impairment suffered by Claimant, Dr. Garcia-Grande testified that as far as ability to function at work, it would be "Class V extreme" according to the American Medical Association (AMA) Guidelines. *Id*. at 20. He noted that "Class V" impairment levels preclude useful functioning. *Id*. Dr. Garcia-Grande stated: "What I mean is that he is not totally 100 percent incapacitated in the sense that he is able to get dressed and feed himself and things of that nature, but as far as functioning in society, he is not able to, so it would be Class V, extreme impairment."[30] *Id*.

12. *Dr. Anastasio Castiello*

Dr. Anastasio Castiello testified on behalf of Employer by way of deposition on November 5, 2003. He is a medical doctor specializing in psychiatry. EX 20:3. He has a general practice of adult psychiatry, though at the time, a good part of his practice was forensic, involving evaluation and treatment of mostly injured workers and criminal cases. *Id*. He testified that Claimant denied any history of psychiatric illness or treatment. *Id*. at 9. Claimant acknowledged that he had been examined by Dr. Garcia-Grande at some point but received no treatment from him or any other psychiatrist or mental health professional. *Id*. at 10. He also denied a history of drinking, drug misusage, and anti-social behavior. *Id*. He did mention that he had been arrested once many years prior for DUI. *Id*. Claimant purported to be in good health prior to March 2001, except that he had been suffering from diabetes for about twenty (20) years. *Id*. He explained that since the accident, he had had a number of medical problems, including headaches, pain to the back, pain to the left leg, and a problem with his eyes. *Id*. He commented that he had lost his eyesight completely in the right eye and that he had all kinds of medical problems. *Id*. Claimant also told Dr. Castiello that in 1988 he had suffered another on-the-job injury, and that he was off work for four (4) years before he recuperated totally and went back to work. *Id*. He also mentioned that he had been involved in an automobile accident about

[30] According to the Florida Guidelines regarding impairment levels, Dr. Garcia-Grande opined that Claimant would be approximately "15 percent plus." He further stated: "It's at least between 15 and 24 percent, because in the Florida [Guidelines] you have moderately severe deficit for reduction and that's 15 to 24 percent, and then severe deficit and reduction is 25 percent plus."

a year prior, presumably at some point in 2002. *Id*. Claimant stated that he had injured his low back at the time, but that the injury was resolved with treatment. *Id*. at 11. Claimant also provided Dr. Castiello with a list of medications that he was currently taking. *Id*.

Regarding the March 22, 2001 accident, Claimant told Dr. Castiello that "he was doing whatever his duties were, and … his left big toe was crushed by some metal object." *Id*. Claimant was seen "at the clinic or doctor's office" and received some treatment that did not solve the problem. *Id*. He then "went into complaining of having headaches at the time, he needed medication, and how he was actually feeling at the present time, not at the time of the accident." *Id*. at 12. Dr. Castiello testified that "[Claimant] then complained of everything being terrible, doing nothing. He made some comments about his wife, how he could not sleep, how he was also losing weight. He started to cry while describing all that. Again and again commented, I have no activities whatsoever, that he had to be pushed by his wife to even take care of his needs, such as taking a bath." *Id*.

Dr. Castiello stated that Claimant described in some detail his marital situation. He told Dr. Castiello that he and his wife were very happy. *Id*. He also mentioned that his wife was from the Philippine Islands and that they had pursued a long-distance courtship where Claimant would fly to the Philippines repeatedly. *Id*. Claimant noted that he was able to do so "because of his seniority at the port, and being allowed to work as he pleased, as much as he wanted or did not want." *Id*. Claimant stated that he and his wife no longer had a physical relationship but that "there was a great deal of love." *Id*.

Claimant indicated that prior to the accident he had been in the process of going into the real estate business and that his idea had been to "buy property that needed to be fixed" and resell it. *Id*. at 13. He ended up not pursuing this, however. *Id*. Claimant specifically complained that "at the time of the accident he had given a deposit on a certain piece of property, and that transaction couldn't be completed, and as a result of that he had lost $5000." *Id*. Dr. Castiello mentioned that this was the "only time that [Claimant] actually talked about money in the specifics because he was very hesitant to address the issue of money in general, as to compensation or whatever he received or did not receive money-wise." *Id*.

Dr. Castiello testified that he performed a mental status examination during which he observed how the Claimant acted, responded, and behaved, as well as how the he was able to relate and give information. *Id*. at 13-14. Dr. Castiello stated that Claimant used a cane to move about "very loosely" and that Claimant "did not lean on the cane" but rather "just had the cane in his hands, literally." *Id*. at 14. He further testified that Claimant's appearance was "socially acceptable," meaning that "he was neatly dressed and groomed." *Id*. Claimant appeared "very guarded and carefully considered every question and every situation before offering an answer or an explanation." *Id*. He "often would become tangential, or did not answer certain questions, even though other times he was very open, explicit, clear, and evidently had the capacity to do so at will." *Id*. Claimant was "fully oriented" and "of course … knew who he was and where he was and why." *Id*. Claimant "had the ability to recall information from the past" and provided information about his family history when questioned about it. Dr. Castiello stated that this was "sort of an opposite [sic] to when I questioned [Claimant] about his way of life for many years

since he was working here in Miami and had been married, divorced and so on, and he really ignored those lines of questions, talking about practicing sports and nothing else." *Id*. at 14-15.

Claimant "denied having symptoms of an active mental disorder." *Id*. at 15. Rather, he "sort of expressed the opinion that he just wanted to return to the way of life he had prior to the accident, and that included health issues." *Id*. Claimant "wanted to be in a situation where he didn't have any more high blood pressure, the diabetes was under control, recovery in the eyesight he had lost to the right eye, and having no pains or numbness." *Id*. Dr. Castiello assessed that "[i]n general, [Claimant] appeared to be functioning at an average intellectual capacity" and that there was "no inability to form rational concepts." *Id*.

When asked whether he tested affective response, Dr. Castiello stated that at all times Claimant "appeared quite bland" and that there were "certain times or moments where [Claimant] sort of cried to sort of attempt to dramatize a comment he was making." *Id*. at 15-16. In sum, Dr. Castiello testified that Claimant responded in a very "non-spontaneous manner."[31] *Id*. at 16. He did not think that Claimant's ability to recognize reality was impaired and Claimant did not say anything to indicate that he had been isolated from reality. *Id*. Dr. Castiello indicated that Claimant seemed to have "a clear tendency to look at things in his own way, perceptions" and "did not appear to have the best of judgment and the capacity or the ability to develop insight into situations based on factual information." *Id*.

Dr. Castiello opined that Claimant was "manifesting elements of severe personality disorder." *Id*. at 17. Specifically, Claimant had "maintained an element of adjustment for life according to his personality and outlook on life. Those personality characteristics were being manifested in connection with the present situation [i.e. the litigation]." *Id*. When asked if Claimant mentioned any prior litigation, Dr. Castiello responded: "[Claimant] indicated to me that he had an on-the-job injury in 1988. That as a result of a fracture to the left foot … he was treated at Jackson Memorial Hospital, and then he was off work for four years."[32] *Id*. at 18. Dr. Castiello stated that the psychiatric significance of this statement is that, because Claimant had been exposed to litigation in the past, nothing that "is going on now is new to him."[33] *Id*. Although Claimant did mention that he had been compensated as a result of the prior litigation, he told Dr. Castiello "not much" else about it.[34] *Id*. Dr. Castiello reiterated that "regarding financial matters, [Claimant] did not comment except when he described the alleged loss of a $5000 deposit in connection with property that he was in the process of buying in March of 2001." *Id*. at 18-19.

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[31] Dr. Castiello's report indicated that Claimant's "affective response was constricted with histrionic elements." EX 20:16.

[32] Dr. Castiello testified that Claimant did not state what happened after those four (4) years; rather, he just indicated that he recuperated completely and was able to return to work "full duty." EX 20:19.

[33] Although not entirely clear, it seems that Dr. Castiello meant that the process of litigation was therefore not new to Claimant.

[34] Claimant indicated that he was compensated for four (4) years for a foot fracture, plus benefits. EX 20:19.

Dr. Castiello opined that Claimant did not have "any interest in any form of psychiatric treatment." *Id*. at 21. The basis for his opinion was "the way [Claimant] described information, and the way he gave a history of himself, and in the way he was presented in his present or actual situation [sic]. He made very clear what he expected, that needed to be corrected, and nothing else. He was very specific." *Id*. at 22. Specifically, Claimant "made very clear that his problems were related to his pain, the numbness, the high blood pressure, the control of the diabetes, and the eyesight deterioration, and that is where the issues that he anticipated should be corrected [sic]." *Id*. Dr. Castiello, however, did not believe that any of those elements were related to the March 22, 2001 toe injury based on the description that Claimant gave of the symptoms and how they manifested. *Id*. Dr. Castiello stated that "credibility [of the Claimant] is a factor" in making a proper diagnosis, and that Claimant "appeared opinionated, uncritical, self-serving in most of his presentations concerning the accident."[35] *Id*. at 22-23. On cross-examination, Dr. Castiello admitted that, while he did not doubt the sincerity of Claimant with respect to the symptoms, he did doubt his sincerity with respect to how the symptoms developed and when and where. *Id*. at 30.

Dr. Castiello stated that he recalled Dr. Garcia-Grande's diagnosis of Claimant and that Dr. Garcia-Grande mentioned "depression" in connection with Claimant. *Id*. at 24. When questioned as to whether he disagreed with the diagnosis made by Dr. Garcia-Grande, Dr. Castiello responded: "Well, that is his opinion. I am sure he must have put together that in his own mind to come up with that conclusion. Based on my data and in my opinion, I don't see that as the issue here. But once again, it's just a matter of opinions." *Id*. Dr. Castiello stated that, although it was "not crucial" that Dr. Garcia-Grande was not aware that Claimant had been compensated for his 1988 on-the-job injury, this was still "important data since we are dealing here with litigation, whether we like it or not, from the medical or psychiatric standpoint." *Id*. at 24-25. Dr. Castiello further testified: "[I]t's important because someone who has been through litigation reacts and acts totally different than someone who has never been involved with litigation. We all know that's another way of life." *Id*. at 25.

Dr. Castiello opined that Claimant did not sustain a permanent injury from a psychiatric standpoint as a result of the toe injury on March 22, 2001. *Id*. at 27. He found no indication of post-traumatic stress disorder or similar psychiatric condition from his exam. *Id*. With regard to whether Claimant had the ability to work from a psychiatric standpoint, Dr. Castiello testified: "[S]trictly from the psychiatric standpoint and without consideration to nothing else [sic], I think he could do whatever work he has done over the years." Id. at 28. He further opined that Claimants "severe personality disorder"[36] was present prior to the toe injury. *Id*. at 29.

13. *Medical Records*

[35] Dr. Castiello later clarified that by self-serving he meant: "[Claimant] does have serious medical problems … but that is not the way he sees it. He knows he has some medical problems, but the emphasis on his part is to link it all to the litigation, link it all to the problem of litigation and nothing else. That is self-serving." EX 20:49.

[36] By "severe personality disorder," Dr. Castiello was referring to his assessment of Claimant as an "opinionated, uncritical individual." EX 20:29. He noted that "inflexibility in relating to situations is a landmark of a personality disorder." *Id*.

The following is a list of information pertinent to this claim taken from medical records and reports:

- A medical report dated October 14, 2003, and written by Dr. Arthur Segall, Jr., notes that a medical record from Jackson Memorial Hospital dated March 9, 1991, shows that Claimant was diagnosed with "diabetes mellitus out of control" and had a blood sugar level of 287. *See* CX 2.

- A medical report dated October 14, 2003, and written by Dr. Arthur Segall, Jr., notes that on May 4, 1999, Claimant had a glucose plasma of 311. *See* CX 2.

- A medical report dated October 14, 2003, and written by Dr. Arthur Segall, Jr., notes that on October 1, 1999, Claimant had a glucose plasma of 315. *See* CX 2.

- A letter dated June 5, 2002, and written by Dr. Roy Loo of the Bascom Palmer Institute states: "Garnett Murray has been under my care since September of 2001" and "is legally blind fro proliferative retinopathy." *See* CX 2.

- A letter dated October 8, 2002, and written by Claimant to Dr. Herbert Pardell states that Claimant is legally blind from diabetic retinopathy. *See* CX 2.

- An Operative Report dated September 19, 2001, and written by Dr. Roy Loo of Bascom Palmer Institute states that the operation performed on Claimant was a pars plana vitrectomy.

- A letter dated April 17, 2002, and written by Dr. Jeffrey Galitz indicates that Claimant reached MMI on February 7, 2003,[37] after successful fusion of the interphalangeal joint of his great left toe. It further stated that using the AMA Guidelines 3rd Edition Revised, Claimant had a PPD of 5% of the foot and that Claimant would be in need of orthotics and a morton's extension. *See* CX 3.

- A letter dated April 3, 2002, and written by Dr. Jeffrey Galitz indicates that Claimant reached MMI on February 7, 2003,[38] after successful fusion of the interphalangeal joint of his great left toe. It further stated that using the AMA Guidelines 3rd Edition Revised, Claimant had a PPD of 2% of the body as a whole. *See* CX 3.

- An undated, handwritten note written by Dr. Jeffrey Galitz indicates that Claimant reached MMI on February 7, 2003,[39] after successful fusion of the interphalangeal joint of his great left toe. It further stated that using the AMA Guidelines 3rd Edition Revised, Claimant had a PPD of 7% of the body as a whole. *See* CX 3.

[37] This date appears to be a typographical error; it seems that Dr. Galitz meant 2002.

[38] This date appears to be a typographical error; it seems that Dr. Galitz meant 2002.

[39] This date appears to be a typographical error; it seems that Dr. Galitz meant 2002.

- A letter dated May 15, 2002, and written by Dr. Jeffrey Galitz indicates that Claimant's ankylosis of the interphalangeal joint in neutral position equates to a 45% impairment of the great toe which equates to 8% of the foot. Not 5% of previously documented. *See* CX 3.

APPLICABLE STANDARDS

Injury Arising Out of Employment

To establish a *prima facie* claim for compensation, a claimant has the burden of establishing that: (1) the claimant sustained physical harm or pain; and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused, aggravated, or accelerated the harm or pain. ***Port Cooper/T. Smith Stevedoring Co., Inc. v. Hunter***, 227 F.3d 285, 287 (5th Cir. 2000); ***Kier v. Bethlehem Steel Corp.***, 16 BRBS 128, 129 (1984). Once this *prima facie* case is established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. 33 U.S.C. § 920(a); ***Hunter***, 227 F.3d at 287.

In order to show harm or injury a claimant must show that something has gone wrong with the human frame. ***Crawford v. Director, OWCP***, 932 F.2d 152 (2nd Cir. 1991). An injury cannot be found absent some work-related accident, exposure, event or episode, and while a claimant's injury need not be caused by an external force, something still must go wrong within the human frame. ***Schoener v. Sun Shipbuilding and Dry Dock Co.***, 8 BRBS 630, 632 (1978). Under the aggravation rule, if an employment injury aggravates, accelerates, exacerbates, contributes to or combines with a previous infirmity, disease, or underlying condition, the employer is liable for compensation for, not just the disability resulting from the employment injury, but instead, for the employee's total resulting disability. ***Strachan Shipping Co. v. Nash***, 782 F.2d 513, 517 (5th Cir. 1986); ***Independent Stevedore Co. v. O'Leary***, 357 F.2d 812 (9th Cir. 1966).

"Once the presumption in Section 20(a) is invoked, the burden shifts to the employer to rebut it through facts--not mere speculation--that the harm was *not* work-related." ***Conoco, Inc. v. Director, OWCP***, 194 F.3d 684, 687-688 (5th Cir. 1999). Thus, once the presumption applies, the relevant inquiry is whether Employer has succeeded in establishing the lack of a causal nexus. ***See Gooden v. Director, OWCP,*** 135 F.3d 1066, 1068 (5th Cir. 1998); ***Bridier v. Alabama Dry Dock & Shipbuilding Corp.***, 29 BRBS 84, 89-90 (1995) (failing to rebut presumption through medical evidence that claimant suffered an unquantifiable hearing loss prior to his compensation claim against employer for a hearing loss); ***Hampton v. Bethlehem Steel Corp.***, 24 BRBS 141, 144-45 (1990) (finding testimony of a discredited doctor insufficient to rebut the presumption); ***Dower v. General Dynamics Corp.***, 14 BRBS 324, 326-28 (1981) (finding a physician's opinion based on a misreading of a medical table insufficient to rebut the presumption). Citing ***Noble Drilling v. Drake***, 795 F.2d 478, 481 (5th Cir. 1986), the Fifth Circuit further elaborated in ***Conoco***:

> To rebut this presumption of causation, the employer was required to present *substantial evidence* that the injury was not caused by the employment. When an employer offers sufficient evidence to rebut the presumption--the kind of evidence a reasonable mind might accept as adequate to support a conclusion--only then is the presumption overcome; once the presumption is rebutted it no longer affects the outcome of the case.

Conoco, Inc., 194 F.3d at 690 (citations omitted and emphasis in original, going on to state that the hurdle for the employer is far lower than a "ruling out" standard); *see also* ***Stevens v. Todd Pacific Shipyards Corp.***, 14 BRBS 626, 628 (1982), *aff'd mem.* 722 F.2d 747 (9th Cir. 1983) (the employer need only introduce medical testimony or other evidence controverting the existence of a causal relationship and need not necessarily prove another agency of causation to rebut the presumption of Section 20(a) of the Act); ***Holmes v. Universal Maritime Serv. Corp.***, 29 BRBS 18, 20 (1995) (the "unequivocal testimony of a physician that no relationship exists between the injury and claimant's employment is sufficient to rebut the presumption."). If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. ***Del Vecchio v. Bowers***, 296 U.S. 280, 286 (1935); ***Port Cooper/T Smith Stevedoring Co. v. Hunter***, 227 F.3d 285, 288 (5th Cir. 2000); ***Holmes***, 29 BRBS at 20. In such cases, I must weigh all of the evidence relevant to the causation issue. If the record evidence is evenly balanced, then the employer must prevail. *Director**, OWCP v. Greenwich Colleries***,** 512 U.S. 267, 281 (1994).

Disability

Disability under the Act is defined as "incapacity because of injury to earn wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Disability is an economic concept based upon a medical foundation distinguished by either the nature (permanent or temporary) or the extent (total or partial). A permanent disability is one which has continued for a lengthy period and is of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. ***Watson v. Gulf Stevedore Corp.***, 400 F.2d 649, 654 (5th Cir. 1968); ***Care v. Washington Metro Area Transit Authority***, 21 BRBS 248, 251 (1988). The traditional approach for determining whether an injury is permanent or temporary is to ascertain the date of maximum medical improvement (MMI). The determination of when MMI is reached, so that a claimant's disability may be said to be permanent, is primarily a question of fact based on medical evidence. ***Seidel v. General Dynamics Corp.***, 22 BRBS 403, 407 (1989); ***Stevens v. Lockheed Shipbuilding Co.***, 22 BRBS 155, 157 (1989); ***Trask v. Lockheed Shipbuilding & Construction Co.***, 17 BRBS 56, 60 (1985). An employee is considered permanently disabled if he has any residual disability after reaching MMI. ***Louisiana Insurance Guaranty Assn. v. Abbott***, 40 F.3d 122, 125 (5th Cir. 1994); ***Sinclair v. United Food & Commercial Workers***, 23 BRBS 148, 156 (1989). A condition is permanent if a claimant is no longer undergoing treatment with a view towards improving his condition, ***Leech v. Service Engineering Co.***, 15 BRBS 18, 21 (1982), or if his condition has stabilized, ***Lusby v. Washington Metropolitan Area Transit Authority***, 13 BRBS 446, 447 (1981).

The Act does not provide standards to distinguish between classifications or degrees of disability. Case law has established that in order to establish a prima facie case of total disability under the Act, a claimant must establish that he can no longer perform his former longshore job due to his job-related injury. ***New Orleans (Gulfwide) Stevedores v. Turner***, 661 F.2d 1031, 1038 (5th Cir. 1981); ***P&M Crane Co. v. Hayes***, 930 F.2d 424, 429-30 (5th Cir. 1991); ***SGS Control Serv. v. Director, OWCP***, 86 F.3d 438, 444 (5th Cir. 1996). He need not establish that he cannot return to *any* employment, only that he cannot return to his former employment. ***Elliot v. C&P Telephone Co.***, 16 BRBS 89, 91 (1984). The same standard applies whether the claim is for temporary or permanent total disability. If a claimant meets this burden, he is presumed to be totally disabled. ***Walker v. Sun Shipbuilding & Dry Dock Co.***, 19 BRBS 171, 172 (1986). A doctor's opinion that return to the employee's usual work would aggravate his condition may support a finding of total disability. ***Care v. Washington Metro Area Transit Authority***, 21 BRBS 248, 251 (1988). A finding of disability may be established based on a claimant's credible subjective testimony. ***Director, OWCP v. Vessel Repair, Inc.***, 168 F.3d 190, 194 (5th Cir. 1999) (crediting employee's reports of pain); ***Mijangos v. Avondale Shipyards, Inc.***, 948 F.2d 941, 944-45 (5th Cir. 1991) (crediting employee's statement that he would have constant pain in performing another job).

Once the *prima facie* case of total disability is established, the burden shifts to the employer to establish the availability of suitable alternative employment. ***P&M Crane***, 930 F.2d at 430; ***Turner***, 661 F.2d at 1038; ***Clophus v. Amoco Prod. Co.***, 21 BRBS 261, 265 (1988). Total disability becomes partial on the earliest date on which the employer establishes suitable alternative employment. ***Palombo v. Director, OWCP***, 937 F.2d 70, 73 (D.C. Cir. 1991); ***Rinaldi v. General Dynamics Corp.***, 25 BRBS 128, 131 (1991). An employer may establish suitable alternative employment retroactively to the day Claimant reached maximum medical improvement, even if the jobs are no longer available at the time of the survey. ***New Port News Shipbuilding & Dry Dock Co. v. Tann***, 841 F.2d 540 (4th Cir. 1988); ***Bryant v. Carolina Shipping Co., Inc.***, 25 BRBS 294, 296 (1992). An employer may also establish suitable alternative employment by offering the claimant a position within its facility so long as it does not constitute sheltered employment. ***Walker v. Sun Shipbuilding & Dry Dock Co.***, 19 BRBS 171, 172 (1986); ***Darden v. Newport News Shipbuilding & Dry Dock Co.***, 18 BRBS 224 (1986).

The claimant may still establish total disability, however, if he establishes that he diligently tried and was unable to secure such employment. ***Palombo***, 937 F.2d at 73; ***Roger's Terminal and Shipping Corp. v. Director, OWCP***, 784 F.2d 687, 691 (5th Cir. 1986).

Compensation for total or partial disability is based on the claimant's pre-injury "average weekly wages." *See* 33 U.S.C. §§ 908 and 910. Compensation for partial disability is based on the difference between the claimant's pre-injury average weekly wage and post-injury wage earning capacity. The determination of wage earning capacity is governed by Section 8(h) of the Act, 33 U.S.C. § 908(h).

DISCUSSION

Left Great Toe Claim

Section 8 of the Act identifies four different categories of disability and separately prescribes the methods of compensation for each. *See* ***Steevens v. Umpqua River Navigation***, ___ BRBS ___ (BRB Nos. 00-1027 and 00-1027A) (July 17, 2001). For purposes of this case, the relevant categories of disability are (1) temporary total and (2) permanent partial. First, in the temporary total disability category, Claimant is entitled to two-thirds of his AWW for the length of time that he was totally disabled. 33 U.S.C. § 908(b). Second, in the permanent partial disability category, Section 8(c) provides a compensation schedule which covers 20 different specific injuries, 33 U.S.C. § 8(c)(1)-(20). The Act at 33 U.S.C. § 8(c)(8) specifically addresses scheduled injury awards based on the loss of a great toe. Since Claimant's permanent disability is to a member identified in the schedule, he is entitled to receive two-thirds of his average weekly wage for a specific number of weeks, regardless of whether his earning capacity had been impaired. *See* ***Henry v. George Hyman Construction Co.***, 749 F.2d 65, 17 BRBS 39 (CRT) (D.C. Cir. 1984). However, I also note that "schedule injury awards may be based not only on total or partial loss of a member, but on total or partial loss of its use" *See* 33 U.S.C. §§ 908(c)(18)(19); ***Travelers Ins. Co. v. Norton***, 30 F. Supp. 119 (E.D. Pa. 1939); ***Conteh v. Greyhound Lines***, 8 BRBS 874, 875 (1978), and that this caveat applies to the case at bar, since Claimant did not lose his great toe but rather lost permanent use of it. The Board and the circuit courts have consistently held that a schedule award runs for the proportionate number of weeks attributable to the loss of use of the member at the full compensation rate of two-thirds of the AWW. ***Nash v. Strachan Shipping Co.***, 15 BRBS 386, 391 (1983), *aff'd in relevant part but rev'd on other grounds*, 760 F.2d 569, 17 BRBS 29 (CRT)(5th Cir. 1985), *aff'd on recon. en banc*, 782 F.2d 513, 18 BRBS 45 (CRT)(5th Cir. 1986). Finally, I note that the Claimant's partial disability is to be considered permanent when he reaches the point of maximum medical improvement (MMI). ***James v. Pate Stevedoring Co***., 22 BRBS 271, 274 (1989); ***Phillips v. Marine Concrete Structures***, 21 BRBS 233, 235 (1988); ***Trask v. Lockheed Shipbuilding & Constr. Co.***, 17 BRBS 56, 60 (1985).

In this case, the Employer accepted compensability of the left great toe injury and paid temporary total disability from March 23, 2001 through April 5, 2001, for a total of $1443.32, and from June 5, 2001 through February 26, 2002, for a total of $27,526.28. The Employer paid permanent partial disability from February 27, 2002 through April 8, 2002, in the amount of $4438.21. The Employer paid the scheduled injury award based upon a three (3) percent impairment rating of the foot. The Employer has denied compensation since that time. *See* Tr. 8-10, 12-13. Accordingly, the two outstanding issues with regard to Claimant's toe injury are: (1) the impairment rating assigned to it; and (2) the date of maximum medical improvement.

Impairment Rating of Left Great Toe

In his post-hearing brief, Claimant argues that the scheduled injury award was based upon "a three (3) percent impairment rating of the foot from Dr. Stein, despite the fact that the authorized, treating, board certified, foot specialist had opined that [Claimant] sustained an [eight (8) percent] impairment to the foot." *Claimant's Brief* at 18. Dr. Galitz, the board certified foot surgeon who testified on behalf of Claimant, assigned the following impairment ratings at a May 15, 2002 Independent Medical Evaluation ("IME"): forty five (45) percent of the great toe; eight (8) percent of the foot; six (6) percent of the lower extremity; and two (2) percent of the whole

person. CX 1:31. He stated that, to the extent that Claimant could tolerate prolonged walking or standing, he would not restrict Claimant in terms of these activities. *Id*. Rather, restrictions would be imposed on an as-tolerated basis. *Id*. Dr. Segall, the board certified podiatrist and foot and ankle surgeon who testified on behalf of Employer, assigned the following impairment ratings at an October 14, 2003 IME: thirteen (13) percent of the foot; nine (9) percent of the lower extremity; and four (4) percent of the whole person. EX 18:22. He further opined that Claimant should be able to work full duty without restrictions. *Id*. at 22-23. Dr. Millheiser, the board certified orthopedic surgeon who testified on behalf of Employer, assigned the following impairment ratings at an October 7, 2003 IME: ten (10) percent of the toe; two (2) percent of the foot; one (1) percent of the lower extremity; (1) percent of the whole person. EX 19:21. He testified that from an orthopedic standpoint, Claimant had no physical work restrictions. *Id*. at 23. Finally, Dr. Stein, the board certified orthopedic surgeon who provided a medical report on behalf of Employer, assigned a three (3) percent impairment rating to Claimant's foot. EX 7:9. He stated that Claimant could work relevant to the foot injury on a regular and full time basis without limitation. *Id*.

The important comparison here is among the impairment ratings assigned specifically to Claimant's foot and how these impairment ratings relate to Claimant's impairment of the body as a whole. Dr. Galitz assigned an eight (8) percent impairment rating to Claimant's foot, Dr. Segall assigned a thirteen (13) percent impairment rating to Claimant's foot, Dr. Millheiser assigned a two (2) percent impairment rating to Claimant's foot, and Dr. Stein assigned a three (3) percent impairment rating to Claimant's foot. Dr. Galitz assigned a two (2) percent impairment rating to the body as a whole, Dr. Segall assigned a four (4) percent impairment rating to the body as a whole, Dr. Millheiser assigned a one (1) percent impairment rating to the body as whole, and Dr. Stein declined to assign an impairment rating to the body as a whole. In addition, the qualifications of each physician must factor into a determination of how much weight to accord each opinion. Drs. Millheiser and Stein are arguably the most qualified of the physicians in that they are board certified orthopedic surgeons. Both Drs. Galitz and Segall possess the lesser qualified title of being board certified foot surgeons. However, I also note that when an injured employee seeks benefits under the Longshore and Harbor Workers' Compensation Act (LHWCA), a treating physician's opinion is entitled to "special" weight, and that Dr. Galitz qualifies as a treating physician in this case.[40] ***Amos v. Director, Office of Workers' Compensation Programs***, 153 F.3d 1051 (9th Cir., 1998); *See also*, ***American Stevedoring Ltd. v. Marinelli***, 248 F.3d 54, (2nd Cir., 2001)***; Lozada v. Director, Office of Workers' Compensation Programs***, U.S. Dept. of 1991 A.M.C. 303 C.A.2,1990; Longshore and Harbor Workers' Compensation Act, §§ 1 et seq.[41] Given these factors, I conclude that Dr. Galitz's opinion is entitled to special weight as a treating physician and that the opinions of Drs. Millheiser and Stein are entitled to added weight given their superior qualifications as board

[40] Dr. Galitz saw Claimant nearly a dozen times. These visits took place both before and after Claimant's toe surgery. In addition, it was Dr. Galitz who performed Claimant's toe surgery. Based on this intense contact with Claimant, I conclude that Dr. Galitz qualifies as a treating physician.

[41] In ***Pietrunti v. Director, Office of Workers' Compensation Programs***, 119 F.3d 1035 (2nd Cir., 1997) an ALJ's findings were reversed by the court because he failed to attribute "great" weight to the opinion of a treating physician.

certified orthopedic surgeons. Dr. Segall's opinion is entitled to less weight than the opinions of Drs. Galitz, Millheiser, and Stein because he does not qualify as a treating physician nor does he possess special medical credentials. In addition to the importance of the physicians' qualifications, I also note the foundational significance of a well reasoned and well documented medical opinion. ***Clark v. Karst-Robbins Coal Co.***, 12 B.L.R. 1-149 (1989) (*en banc*). *See also* ***Mabe v. Bishop Coal Co.***, 9 B.L.R. 1-67 (1986) (a report which is internally inconsistent and inadequately reasoned may be entitled to little probative value).[42]

I must now turn to the substance of each medical opinion. Dr. Galitz testified that the impairment ratings he assigned were based on the AMA Guide, Third Edition. CX 1:27. He pointed out that, although this was not the most recent edition of the AMA Guide, it was the most recent edition that included the pertinent information in that it specifically addressed the interphalangeal joint. *Id*. at 27-30. Dr. Segall testified that the impairment ratings he assigned were based on the AMA Guide, Fifth Edition, but he could not state what these ratings would translate to with respect to the toe because the AMA Guide, Fifth Edition, provided ratings only for the whole person, lower extremity, and foot. EX 18:22-23. Dr. Millheiser testified that the impairment ratings he assigned were based on the AMA Guide, though he failed to specify which edition. He did point out, however, that the AMA Guide on which he relied did not include impairment ratings for ankylosis of the IP joint. EX 19:39-42. Therefore, he extrapolated. *Id*. He noted that ankylosis of the entire toe, including the MP joint in a position of function, would be thirteen (13) percent of the foot; nine (9) percent of the lower extremity; and four (4) percent of the whole body. *Id*. He explained that, since the main problem in an ankylosis of a toe would be a problem with the MP joint of the hallux, the permanent impairment rating by extrapolation for the IP joint would be considerably less. *Id*. He stated that thirteen (13) percent of the foot for ankylosis of both joints of the toe is equal to approximately sixty nine (69) to seventy three (73) percent impairment of the great toe. *Id*. However, the impairment of the great toe with an ankylosis only of the IP joint is certainly much less as the main function of the toe and gait is the function of flexion of the MP joint upon take off. *Id*. Therefore, Claimant's impairment rating would be in the range of ten (10) percent of the toe; two (2) percent of the foot; one (1) percent of the lower extremity; and one (1) percent of the whole body. *Id*. Dr. Stein stated that the impairment ratings he assigned were based on the AMA Guide, Fourth Edition. EX 7:9. Like Dr. Segall, Dr. Stein also declined to assign an impairment rating to the toe specifically. *Id*. Further, Dr. Stein declined to assign an impairment rating to the body as a whole. *Id*.

While Dr. Galitz did not rely on the most recent edition of the AMA Guide, he reasoned that relying on the edition that included the most specific impairment ratings (i.e. a rating for the toe) would yield the most accurate results. I accept Dr. Galitz's contention that the AMA Guide, Third Edition, while not the most recent edition, yields the most accurate results in that it contains the most specific information relating to the toe. By contrast, Dr. Segall relied on the most recent edition of the AMA Guide but was admittedly unable to obtain a specific impairment rating for the toe from this edition. While I do not discredit the impairment ratings assigned by Dr. Segall, even though he relied on an admittedly less specific but more recent edition, I note

[42] Although these are cases under the Black Lung Benefis Act, their application is the same.

that his reliance on this edition may have skewed his impairment ratings to some degree. Dr. Millheiser declined to note which AMA edition he used, though he did provide a somewhat well reasoned opinion with regard to the impairment ratings he assigned. He noted that the AMA Guide he used did not provide impairment ratings relating specifically for the IP joint; therefore, he extrapolated based on the impairment ratings regarding the MP joint. I find that this represents a well reasoned approach.[43] By contrast, while Dr. Stein relied on a recent edition of the AMA Guide, he failed to provide an impairment rating for the toe or the whole body, and did not even acknowledge the shortcomings of the this edition in this regard.

Given these variables, I conclude that Dr. Galitz's opinion is highly probative given that he was Claimant's treating physician, his opinion was well reasoned, and he provided specific impairment ratings. I conclude that Dr. Millheiser's opinion is also quite probative given that he is a board certified orthopedic surgeon, his opinion was well reasoned, and he employed a sound approach in providing specific impairment ratings under the circumstances. I find that Dr. Segall's opinion is less probative than that of Drs. Galitz and Millheiser because he was not Claimant's treating physician, he possesses no special medical credentials, and his opinion is not as well reasoned in that the impairment ratings he assigned are less specific and seemingly skewed. Dr. Stein's medical report is as probative as Dr. Segall's opinion. While Dr. Stein's medical report was not as thorough or well reasoned as Dr. Segall's opinion in that he failed to provide impairment ratings for the toe and the whole body, failed to explain why, and did not acknowledge the shortcomings of the most recent edition, he does possess the superior medical credential of being a board certified orthopedist.

The highest impairment rating assigned to Claimant's foot was done so by Dr. Segall, who, ironically, testified on behalf of Employer. He assigned a thirteen (13) percent impairment rating to the foot and a four (4) percent impairment rating to the body as a whole. As stated previously, I find his opinion less probative than that of Dr. Galitz, who assigned an eight (8) percent impairment rating to the foot and a two (2) percent impairment rating to the body as a whole. Dr. Millheiser, whose opinion was also quite probative, assigned a two (2) percent impairment rating to the foot and a one (1) percent impairment rating to the whole person. Although I find that he used sound reasoning in extrapolating to arrive at these impairment ratings, I conclude that these ratings are still less accurate than those assigned by Dr. Galitz. Dr. Stein, whose medical report is as probative as the opinion of Dr. Segall, assigned the lowest impairment rating of three (3) percent to the foot. I conclude that Claimant's scheduled injury award shall be based on the precise impairment ratings provided by Dr. Galitz. These impairment ratings are not only the product of a well-reasoned medical opinion by a treating physician, but they also represent an approximate average of the impairment ratings assigned by all those who testified regarding Claimant's toe injury. The Employer based its scheduled injury award upon the impairment ratings assigned by Dr. Stein, however, and thus the award must be adjusted to reflect the increased impairment ratings assigned by Dr. Galitz: forty five (45) percent of the great toe; eight (8) percent of the foot; six (6) percent of the lower extremity; and two (2) percent of the whole person.

Date of Maximum Medical Improvement

[43] For instance, it is better reasoned than the approach of Dr. Segall, who simply used the higher impairment ratings that applied to the MP joint and did not bother to extrapolate for the IP joint.

As noted previously, Employer accepted compensability of the left great toe injury and paid temporary total disability from March 23, 2001 through April 5, 2001, for a total of $1443.32, and from June 5, 2001 through February 26, 2002, for a total of $27,526.28. The Employer paid permanent partial disability from February 27, 2002 through April 8, 2002, in the amount of $4438.21. The Employer paid the scheduled injury award based upon a three (3) percent impairment rating of the foot. The Employer has denied compensation since that time.

Again, as Dr. Galitz was Claimant's treating physician for his toe, I accord great weight to his opinion with regard to the date of maximum medical improvement ("MMI"). I note that Dr. Galitz's deposition reflects that on February 7, 2002, he discharged Claimant from his service, stated that Claimant had reached MMI with respect to his left great toe, and noted that Claimant could follow-up on an as needed basis.[44] CX 1:25, 46-48. At this time, Dr. Galitz testified that Claimant was given the understanding that nothing further could be done to improve his condition. *Id*. at 54. Dr. Galitz did not see Claimant again until May 30, 2002, at which time Dr. Galitz observed that the fusion site had healed well but that Claimant was having continued back pain. *Id*. at 25-26. At that time, Dr. Galitz reiterated that Claimant had reached maximum medical improvement (MMI) with respect to the left great toe, but that this was not respective of his lower back or any other problems he may have. *Id*. at 26, 48. Importantly, Dr. Galitz clarified in his deposition that the actual date of MMI for Claimant would be February 7, 2002. *Id*. at 48.

As for the MMI dates provided by the other physicians, Dr. Stein concluded in a February 26, 2002 medical report that Claimant had reached MMI with regard to the toe injury and could work on a regular full time basis. EX 7:9. Dr. Segall opined that Claimant had reached MMI with regard to the left great toe on October 14, 2003. EX 18:22. Dr. Millheiser opined that Claimant had reached MMI on October 7, 2003. I note that the MMI dates provided by these three physicians are later than the MMI date provided by Dr. Galitz; however, these physicians examined Claimant after Dr. Galitz did. It is therefore unclear whether they would have determined that Claimant reached MMI earlier had they examined Claimant earlier. As a result, I find that for purposes of determining MMI, the opinions of Drs. Galitz and Stein are most probative, since they had the opportunity to examine Claimant earlier than did Drs. Segall and Millheiser. The record reflects that both Drs. Galitz and Stein opined that Claimant had reached MMI in February 2002. Specifically, Dr. Galitz, who saw Claimant on February 7, 2002, opined that Claimant had reached MMI on that date; Dr. Stein, who saw Claimant on February 26, 2002, opined that Claimant had reached MMI on that date. Significantly, the Employer used the latter of these two dates, February 26, 2002, to determine the date on which it would cease temporary total disability payments. Thus, rather than shortchanging Claimant on his temporary total disability payments, the Employer, if anything, paid Claimant in excess of what he deserved according to the testimony of Claimant's very own board certified foot surgeon. If there is any doubt as to whether the employee has recovered, such doubt should be resolved in favor of the claimant's entitlement to benefits. ***Fabijanski v. Maher Terminals***, 3 BRBS 421, 424 (1976), *aff'd mem. sub nom*. ***Maher Terminals, Inc. v. Director, OWCP***, 551

[44] He also noted that Claimant was to be followed up for his back. Dr. Galitz noted that Claimant may need a custom-made insert for his shoe.

F.2d 307 (4th Cir. 1977). *but see* ***Maher Terminals, Inc. v. Director, OWCP***, 992 F.2d 1277, 27 BRBS 1 (CRT) (3d Cir. 1993), *cert. granted sub nom*. ***Director, OWCP v. Greenwich Colleries***, 510 U.S. 1068 (1994). Accordingly, I will not disturb the MMI date on which the Employer relied in this case, February 26, 2002.

Now that the appropriate MMI date has been determined, I must address the number of weeks that Employer is liable for Claimant's permanent partial disability. In this regard, the correct assessment, pursuant to Section 8(c)(19), is payment at the full compensation rate (two-thirds of the claimant's average weekly wage of $1082.50 for a proportional number of weeks). The number of weeks is calculated by applying the percentage of loss (i.e. forty five (45) percent of the left great toe, according to Dr. Galitz) to the number of weeks stated in Section 8(c)(8) (i.e. thirty eight (38) weeks). Thus, the correct number of weeks is approximately seventeen (17) weeks. However, Employer paid Claimant for only about five (5) weeks (i.e. from February 27, 2002 through April 8, 2002) for his permanent partial disability. Thus, the scheduled injury award must be adjusted to reflect the seventeen (17) week-period for which Employer must compensate Claimant for his permanent partial disability.

Credibility of Claimant

It became apparent at hearing that Claimant is not a credible witness. Several times he made statements to the effect that he could not recall certain crucial events that clearly took place upon inspection of unequivocal medical evidence. He could not recall having been hospitalized for diabetes in 1991, yet medical records show this to have definitively been the case. *See* Tr. at 101-103; CX 2. Claimant did not recall having seen Dr. Galitz after his foot surgery, even though medical evidence of record shows this to have definitively been the case. *See* Tr. at 120; CX 1:13. Claimant did not recall that in 2000, physicians at Bascom Palmer told him to go the laser clinic, yet medical evidence of record shows this to have definitively been the case. *See* Tr. at 126; EX 21:13. Throughout his testimony, Claimant was often unable to answer questions, often stating that he could not remember. Moreover, on direct examination, Claimant's attorney was forced to refresh Claimant's memory several times with regard to basic facts of the case.

Lumbar Spine Claim

Claimant's position is that the "direct and proximal cause of his current back pain and radiculopathy is the work-related accident" of March 22, 2001. *See Claimant's Brief* at 19. To establish a *prima facie* claim with regard to his lumbar spine, Claimant need only show that he sustained physical harm or pain and that an accident occurred in the course of employment, or conditions existed at work, which could have caused, aggravated, or accelerated the harm or pain. The aggravation rule provides that if an employment injury aggravates, accelerates, exacerbates, contributes to or combines with a previous infirmity, disease, or underlying condition, the employer is liable for compensation for, not just the disability resulting from the employment injury, but instead, for the employee's total resulting disability. ***Strachan Shipping Co. v. Nash***, 782 F.2d 513, 517 (5th Cir. 1986); ***Independent Stevedore Co. v. O'Leary***, 357 F.2d 812 (9th Cir. 1966).

Dr. Galitz opined that Claimant developed an aggravation of his low back injury from the accident. CX 1:35. In addition, Dr. Kohrman opined that there were two logical explanations linking Claimant's lumbar spine injury to the accident. *See* CX 4:39-40. First, Claimant could have experienced an acute injury to the low back at the time of the accident by experiencing a type of startled response (i.e. twisting movement at the time of the accident).[45] *See Id*. Second, Claimant could have developed his syndrome as a result of abnormal lumbar biomechanics from his orthopedic injury. *See id*. While Dr. Kohrman was unable to "sort out" which of these two explanations represented the true explanation, he testified that either one would be a logical explanation for Claimant's syndrome. *See id*. at 39-40. I conclude that Claimant has established a *prima facie* claim with regard to his lumbar spine injury. I note that as part of his *prima facie* claim, Claimant must prove that he actually suffered a lumbar spine injury, and that while not all physicians agree that Claimant demonstrated objective signs of a lumbar spine injury, they all would at least give him the "benefit of the doubt" in this regard. EX 19:22; Tr. 165-166. With respect to the issue of whether the injury sustained by Claimant *could have* occurred within the course of his employment, Drs. Galitz and Kohrman provide varying explanations, as noted above. However, since all that is required of Claimant in establishing a *prima facie* claim is to demonstrate that he suffered an injury, which *could have been* caused, aggravated, or accelerated by the accident, I find that he has done so through the opinions of Drs. Galitz and Kohrman. Accordingly, Claimant is entitled to the statutory presumption under Section 20(a).

The burden now shifts to the Employer to establish that Claimant's lumbar spine injury was not caused, aggravated, or accelerated by the accident. To rebut the Section 20(a) presumption, Employer's burden is to present substantial evidence that the injury was not caused by the employment. This evidence is characterized as the kind of evidence a reasonable mind might accept as adequate to support a conclusion. Specifically, the Employer need only introduce medical testimony or other evidence controverting the existence of a causal relationship and need not necessarily prove another agency of causation to rebut the presumption of Section 20(a) of the Act. The unequivocal testimony of a physician that no relationship exists between the injury and Claimant's employment is sufficient to rebut the presumption. Dr. Herskowitz stated that in reviewing Claimant's medical records, he noticed no complaints of back trauma until four (4) or five (5) months after the accident. Tr. at 154. Moreover, he testified that when he examined Claimant on October 24, 2003, Claimant did not describe any trauma to the lumbar spine as a result of the toe injury, did not describe any jarring or jolting of the lumbar spine as a result of the toe injury, and did not describe any falls to the ground as a result of the toe injury.[46] Tr. at 157. With regard to the etiology of Claimant's lumbar spine complaints, Dr. Herskowitz opined that the March 22, 2001 accident was in no way related. *Id*. at 168. He observed that Claimant had undergone previous back injuries and that his medical records demonstrated ongoing complaints of back pain in the past. *Id*. at 167. Dr. Herskowitz

[45] Dr. Kohrman testified on cross examination that he did not get any history from Claimant regarding whether there was any "jolting" or "jarring" involved in the injury, though he later testified on re-direct examination that it would be logical to assume, based on Claimant's description of the accident, that "something like that happened." *Id*. at 39.

[46] This conflicts with Claimant's testimony at the hearing in which he stated that he "fell forward to the ground." Tr. at 68-69. However, as stated previously, I do not find Claimant to be a credible witness. Therefore, I accept Dr. Herskowitz's testimony in this regard.

further stated that Claimant's current back pain could be "a combination of injuries at his work and getting older." *Id*. Dr. Herskowitz unequivocally testified that no relationship existed between the injury Claimant's March 22, 2001 accident. As will be more fully outlined below, Dr. Millheiser also provided unequivocal testimony in this regard. Accordingly, I conclude that Employer has rebutted the Section 20(a) presumption.

Since the Section 20(a) presumption has been rebutted and no longer controls, the record as a whole must be evaluated. The qualifications of each physician must factor into a determination of how much weight to accord each opinion. Dr. Galitz, Claimant's treating physician for his toe injury, also provided an opinion regarding Claimant's lumbar spine injury. However, I note that as a board certified foot surgeon, Dr. Galitz possesses limited expertise on the lumbar spine. Thus, while I accorded great weight to his opinion on Claimant's foot injury, I accord much less weight to his opinion on Claimant's lumbar spine injury.[47] Dr. Kohrman, who testified on behalf of Claimant, and Dr. Herskowitz, who testified on behalf of Employer, are both board certified neurologists.[48] I conclude that they are equally qualified to provide an opinion on Claimant's neurological impairment and lumbar spine injury. Finally, Dr. Millheiser, who testified on behalf of Employer, is a board certified orthopedic surgeon. I conclude that his opinion is entitled to the most weight with regard to Claimant's lumbar spine injury, since he is the only orthopedic surgeon to testify in this case. However, with regard to Claimant's neurological impairment, I find that Dr. Millheiser is less qualified than Drs. Kohrman and Herskowitz.

I must now turn to the substance of each medical opinion. Dr. Galitz's asserted two (2) theories of injury with regard to the lumbar spine. First, he suggested that Claimant developed an aggravation of his low back injury from the accident. CX 1: 35. Then he suggested that it was "not uncommon" for people who are on crutches as a result of foot problems to develop back pain. *Id*. at 33-34. He also indicated that people on crutches as a result of foot problems sometimes develop back pain by aggravating a pre-existing condition. *Id*. He did not know which of these alternatives was more likely in Claimant's case. *Id*. While it is acceptable for Dr. Galitz to set forth two theories of injury (i.e. aggravation of a pre-existing low back condition versus development of back problems on account of being on crutches), I find that his medical opinion lacks thorough exploration into these two theories of injury. He testifies merely as to possibilities and generalities regarding what *could* be causing Claimant's lumbar spine injury. However, he does not pursue these possibilities with any specificity. This deficiency in his medical opinion, combined with the fact that I have found him to possess limited insight into the lumbar spine, renders Dr. Galitz's opinion of little probative value with respect to the lumbar spine injury.[49]

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[47] Even Dr. Galitz himself recommended several times that Claimant be followed up by a different physician for his lumbar spine injury. This demonstrates that not even Dr. Galitz was confident about his knowledge of the lumbar spine.

[48] Dr. Kohrman is also a board certified psychologist.

[49] In ***Drummond Coal Co. v. Freeman***, 17 F.3d 361 (11th Cir. 1994), the Eleventh Circuit held that an administrative law judge "need not . . . find that a medical opinion is either wholly reliable or wholly unreliable"; rather, the opinion may be divided into the relevant issues of entitlement to determine whether it is reasoned and

Next, I will turn to Dr. Kohrman's medical opinion. Dr. Kohrman diagnosed Claimant's lumbar spine injury based on tenderness, muscle spasm, and a positive straight leg test demonstrated on general physical examination. CX 4:10. He testified that Claimant's symptoms were "classic" for lumbar radiculopathy or sciatica. *Id*. at 28. As noted above, Dr. Kohrman testified that there were two logical explanations that would link Claimant's lumbar spine injury to the accident. *See* CX 4:39-40. First, Claimant could have experienced an acute injury to the low back at the time of the accident by experiencing a type of startled response (i.e. twisting movement at the time of the accident).[50] *See id*. Second, Claimant could have developed his syndrome as a result of abnormal lumbar biomechanics from his orthopedic injury. *See id*. While Dr. Kohrman was unable to "sort out" which of these two explanations represented the true explanation, he testified that either one would be a logical explanation for Claimant's syndrome. *See id*. at 39-40.

Dr. Kohrman later explained how his neurological findings related to his findings regarding the lumbar spine. He testified that Claimant demonstrated some degree of diabetic neuropathy in that he had decreased pinprick sensation in the right leg below the ankle and in the left leg, more pronounced than in the right, with decreased pinprick sensation below the left knee.[51] *Id*. at 10. Claimant also demonstrated decreased pinprick sensation in the toes. *Id*. at 12. While diabetic neuropathy is generally expected to be symmetric, here Claimant was experiencing worse symptoms on his left side. *Id*. This was significant inasmuch as it was consistent with Claimant's injury. *Id*. Dr. Kohrman opined that there was probably some superimposed traumatic injury, which could be coming from Claimant's low back. *Id*. He noted that this could be a lumbar radiculopathy (that is, the increased sensory loss in the left leg) or there could be a degree of local nerve injury from the trauma superimposed on his diabetic neuropathy. *Id*. Since Claimant had some degree of sensory loss in both feet and since his right foot was not injured, Dr. Kohrman explained that his right foot represented the "baseline" (i.e. the degree of sensory loss related to generalized symmetrical proliferative neuropathy, which in Claimant's case was probably diabetes in origin). *Id*. at 27. On top of this generalized symmetrical proliferative neuropathy, Claimant was experiencing a further loss of sensation in the left leg. *Id*. This was not consistent with general diabetic neuropathy, which is usually

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documented with regard to any particular issue. Thus, the fact that I find Dr. Galitz's testimony highly reliable with regard to the toe injury is not inconsistent with the fact that I find it minimally reliable with regard to the lumbar spine injury.

[50] As previously noted, Dr. Kohrman testified on cross examination that he did not get any history from Claimant regarding whether there was any "jolting" or "jarring" involved in the injury, though he later testified on re-direct examination that it would be logical to assume, based on Claimant's description of the accident, that "something like that happened." *Id*. at 39.

[51] Claimant's reflexes were normal in the arms, symmetrically decreased at the knees and absent at the ankles. CX 4:13. This finding was consistent with diabetic neuropathy. *Id*. Dr. Kohrman noted that other conditions that can cause absent reflex in the ankles are spinal disease and herniated disc – i.e. "if it were pushing on and irritating the nerves on both sides, the right and left, could cause decreased or absent ankles." *Id*. This is an objective neurological finding. *Id*.

symmetrical in presentation. *Id*. Therefore, Dr. Kohrman opined that Claimant's additional loss of sensation on the left side was due to the accident on March 22, 2001.[52]

Dr. Kohrman also addressed Claimant's altered gait in the context of his lumbar spine injury and neuropathy. He stated that Claimant's gait was slow and antalgic, meaning painful with a limp on the left side, and that he was using a cane which helped him. *Id*. at 12. Claimant was unable to perform a tandem walk test, which is a heel to toe walk on a straight line. *Id*. Dr. Kohrman testified that there was no specific significance to this finding, though he did testify that it was in part due to his back pain and in part due to his neuropathy. *Id*. at 12-13. Dr. Kohrman explained that Claimant's altered gait, due to his foot injury, had potentially altered the normal biomechanics of his spine used for standing upright, sharing responsibility between two legs, and having normal symmetrical movements. *Id*. at 34. Dr. Kohrman testified that it was not uncommon for people to develop low back problems as a result of a prolonged alteration in their lumbar biomechanics. *Id*. He noted that in this specific instance, Claimant's foot injury and the pain and the difficulty he experienced walking properly on the foot represented "another possibility for the flare-up or for the cause of his low back pain." *Id*.

On cross examination, Dr. Kohrman was questioned as to whether he was aware of Claimant's 1988 work injury where he fractured his left ankle. CX 4:29-30. He testified that Claimant had advised him of an "old knee injury" but that Claimant had not recounted any lower back pain in connection with that accident or at any other time prior to the March 22, 2001 accident. *Id*. at 30. Dr. Kohrman also testified that Claimant indicated he had "recovered from [injuries associated with the prior accident]" and was able to return to his work at the port "full time, full duty." *Id*. Dr. Kohrman further stated: "So if there were an M.R.I. scan of the lumbar spine or some diagnostic or nerve conduction studies, an EMG of the left leg from [the time of the prior accident] that indicated that there was a preexisting problem there, then I would certainly be interested in reviewing that." *Id*. However, he concluded that "[r]egardless, even if there were [such evidence], since he became asymptomatic and was able to return to work and now, he's symptomatic again, I would have to consider that as a traumatic exacerbation of an underlying problem." *Id*. Insofar as Dr. Kohrman understood, there was no direct trauma to the back as a result of the previous accident. In other words, Claimant did not fall on his buttocks and apparently nothing struck him in the low back. Dr. Kohrman testified that Claimant did not relate to him any kind of twisting or indirect trauma. *Id*.

[52] On cross examination, Dr. Kohrman admitted that his findings with regard to sensation did not correlate exactly with a dermatonal pattern. CX 4:28. However, he noted that in clinical practice, one does not always expect to see a dermatonal pattern because at times it is difficult for patients to make distinct differentiations, especially when there is some underlying neuropathy, as there was in Claimant's case. *Id*. at 28-29. Thus, while Claimant characterized the decreased sensation as more of a generalized decreased sensation below the knee, there was in fact decreased sensation on the left side below the knee. *Id*. Dr. Kohrman explained that if there were no back pain and no pain radiating down into the left leg, then because there was not a dermatonal pattern, one might assume a proliferative or diabetic neuropathy as opposed to a lumbar radiculpathy. *Id*. at 29. Specifically, he stated: "It would be more likely to be proliferative nerve injury, but in the setting in the context of very exquisitely and anatomically correct dermatonal radiation of pain from low back down into the left leg thigh and calf, that is a dermatonal distribution. *Id*. That's a classic L5 or S-1 nerve root distribution. So in that setting, the decreased sensation in the left leg may very well be coming from low back." *Id*.

While it is acceptable for Dr. Kohrman to set forth two theories of injury (i.e. direct trauma through startled response versus abnormal lumbar biomechanics due to orthopedic injury), I find that these two theories are not particularly well documented nor are they well reasoned. In particular, Dr. Kohrman has no documentation to substantiate the startled response theory. In fact, he even admitted on cross examination that he did not get any history from Claimant regarding whether there was any jolting or jarring involved in the accident. Although he stated that it would be logical to assume, based on Claimant's description of the accident, that "something like that happened", this is too integral a fact to be reduced to mere assumption. Dr. Kohrman's other theory, that Claimant developed abnormal biomechanics due to his orthopedic injury, is based on general notions about what can theoretically happen in the event of an orthopedic injury. Dr. Kohrman stated that it was not uncommon for people to develop low back problems as a result of a prolonged alteration in their lumbar biomechanics. He noted that in this instance, Claimant's foot injury represented "another possibility for the flare-up or for the cause of his low back pain." Again, however, Dr. Kohrman's testimony is only speculative; he merely states that prolonged alteration in Claimant's lumbar biomechanics is a possible explanation for his lumbar spine injury. Finally, the extent to which Dr. Kohrman factored Claimant's previous work injury into his analysis of Claimant's current condition is unclear. He stated that if there were objective evidence (i.e. an M.R.I. scan of the lumbar spine, some diagnostic or nerve conduction studies, or an EMG of the left leg) from the time of the previous injury indicating a preexisting problem, then he would be "interested in reviewing that." Dr. Kohrman concluded that if there were such objective evidence, he would have to consider Claimant's current condition a "traumatic exacerbation of an underlying problem." Thus, the extent to which Dr. Kohrman considered Claimant's 1988 injury, if at all, is wholly unclear.

Next, I will turn to Dr. Herskowitz's opinion. Dr. Herskowitz testified that he reviewed multiple medical records of Claimant and that they demonstrated a multitude of injuries in the past, dating back to 1988, where Claimant had a lot of similar symptomatology and also experienced some medical problems with diabetes creating some neurologic symptoms. Tr. at 153-154. Although Claimant told Dr. Herkowitz that he was unaware of any previous back problems, Dr. Herskowitz knew to inquire about the 1988 accident where Claimant had experienced some back pain and numbness of his feet, since he had reviewed Claimant's medical records.[53] *Id*. at 156. In reviewing Claimant's medical records pertaining to the March 22, 2001 accident, Dr. Herskowitz did not find any complaints of trauma to the back until "four or five months" after the accident. *Id*. at 154. Specifically, "low back pain" was mentioned. *Id*. Significantly, Dr. Herkowitz also testified that when he asked Claimant to describe the accident, Claimant did not mention a fall to the ground. *Id*. at 155. However, Claimant complained to Dr. Herskowitz of having pain radiating up and down his entire left leg and low back during the time that he was followed by the Port of Miami Medical Clinic after the accident. *Id*. at 154. Claimant complained of persistent low back pain, radiating down the whole left leg, with numbness of the entire left foot and poor balance, resulting in falling at times. *Id*. at 156. He used a cane to steady himself and did not sleep well at night because of the pain and numbness in his right foot (not as pronounced as his left foot) and persistent pain in the left big toe. *Id*.

[53] Claimant then stated that his memory was bad and that he had been having more eye problems and memory problems, although he did not sustain any injury to his head in the fall.

Dr. Herskowitz performed various examinations on Claimant, including mental status, motor, sensory, reflex, and cerebellar. The motor examination demonstrated no weakness, though it was difficult to examine Claimant's left leg because of the pain he was experiencing in that leg. *Id*. at 160-161. Dr. Herskowitz noticed no obvious atrophy. *Id*. When Claimant tried to exert himself on the left leg resistance test, he said it was very painful, so Dr. Herskowitz did not pursue that test further. *Id*. at 161. Dr. Herskowitz testified that the neurological significance of the motor findings was that if there had been "an injury to a nerve, damage to the spine and the nerves that go to certain muscles, one will have weakness or atrophy or a decrease in size or bulk of that muscle." *Id*. In Claimant's case, Dr. Herkowitz did not detect any of these problems. *Id*. Rather, he stated that "when I could get [Claimant] to momentarily try and do some strength, I felt it was probably normal." *Id*.

Dr. Herkowitz noted that on the sensory examination, which tests for pin prick, touch, vibration, and different modalities that test perception, diabetic patients often produce abnormal results. *Id*. Dr. Herskowitz testified that when he tested Claimant's entire left leg as compared to his right leg, "everything was abnormal." *Id*. Claimant "couldn't feel any modality. His vibration, his probe perception, which is basically moving a toe up and down with his eyes closed to see if he could perceive which direction it was going in or pin prick, he said everything on the left leg, the entire left leg wasn't as it was on the right leg." *Id*. at 161-162. Dr. Herskowitz testified that Claimant's reaction did not "anatomically fit anything."[54] *Id*. at 162. Accordingly, Dr. Herskowitz opined that there was possibly "some magnification" of Claimant's symptoms, since if Claimant had been experiencing "pinched nerves" in his leg, there should have been a "certain strip or area, defined area in the leg" showing the abnormality. *Id*. Dr. Herskowitz further explained: "It's not globally the whole leg. It's impossible, unless you knock out every nerve that goes to the leg, but that would also affect motor findings, too. If somebody had a left leg that they feel very little, you would expect to find other things." *Id*. Dr. Herskowitz emphasized that this part of the exam was subjective insofar as he was relying on Claimant for information. *Id*. Thus, he did not "give too much credence to that as being a positive for abnormal finding [sic]." *Id*.

Dr. Herskowitz also conducted a reflex examination, which demonstrated that Claimant's reflexes were diminished throughout. *Id*. at 163. He noted, however, that this was "very common in people who have diabetes" and that Claimant was "asymmetrical." *Id*. With regard to how diabetes affects one's neurological condition, Dr. Herskowitz testified that it is very significant, since diabetes "causes degeneration or inflammation of the nerve endings." *Id*. Therefore, he stated, "frequently one has loss of sensation or abnormal perception of sensation. They may feel a burning sensation or they may not feel normal. Many times, if their foot's on the ground, they don't have good perception on where their foot is in space. So it can also cause weakness of affecting the nerve endings." *Id*. Dr. Herskowitz also testified that, generally diabetic neuropathy is a progressive disease that "gets worse over time." *Id*. at 164.

[54] Dr. Herskowitz also stated that the sensory findings were not in a dermatonal pattern. He explained that a dermatonal pattern is when it is anatomic. *Id*. He further explained: "You trace a nerve root from the spine to where it finally goes and that's the area that you would find an abnormality, and I did not find a dermatonal pattern. So, it was just sort of globally diminished which didn't make sense anatomically." *Id*. at 162-163.

Dr. Herskowitz also conducted a cerebellar examination, which basically tests coordination and muscle tone. Claimant's limitations on this exam pertained only to his left; his lower extremities were normal. *Id*. Dr. Herskowitz also conducted a gaited station examination during which he basically watched Claimant walk. *Id*. at 164-165. He noted that Claimant had an antalgic gait, meaning that he was limping or had a painful-type gait. *Id*. at 165. Dr. Herskowitz stated that, "[Claimant] was using the cane, and basically as part of the exam, we get them to heel and toe off to test the various strengths, but he was limited because he said that he had pain performing these functions of his left leg." *Id*. Dr. Herskowitz explained that "hypersensitivity" or "hyperpathia" is super-sensitivity by a patient to an area being touched where there has been nerve damage. *Id*. at 165. He further explained that a patient with nerve damage may feel such sensitivity where an average person would feel just a normal touch. *Id*. He noted that sometimes it may be spontaneous, such as by just putting on a sock, and sometimes surfaces after injuries, especially if there is an injured nerve. *Id*. However, Dr. Herskowitz did not find that Claimant had any "hypersensitivity" or "hyperpathia." *Id*. When questioned as to whether he felt that there was any symptom magnification on the part of Claimant, Dr. Herskowitz responded: "Well, I think in some parts perhaps, as I mentioned in my sensory exam, he may have been trying to magnify somewhat, but again meeting someone on one occasion, I try to give them the benefit of the doubt." *Id*. at 165-166.

In sum, Dr. Herskowitz testified that, based on his review of the medical records and his examinations, Claimant did not suffer a permanent neurological impairment with respect to the March 22, 2001 accident. *Id*. at 166. He noted that Claimant had experienced multiple injuries and had voiced complaints prior to the accident, and that from his examination, he concluded that Claimant's injuries were "really confined to the big toe." *Id*. at 166-167. He further stated that he found it "very unusual that just a localized toe injury can cause this magnitude of complaints." *Id*. at 167. He also stated that "many times we see this many complaints of diabetics but without any other accidents." *Id*. I find Dr. Herskowitz's opinion well reasoned and well supported by the medical evidence and patient history that he considered in his analysis. Although Dr. Herskowitz was inclined to give Claimant the benefit of the doubt, the results of the examinations he conducted suggested that Claimant was exaggerating his symptoms. Dr. Herskowitz emphasized that there was no objective evidence of neurological impairment. Dr. Herskowitz did not believe that Claimant was entitled to an impairment rating under the AMA Guidelines for neurological injury as a result of the accident. *Id*. He did not believe that Claimant had any neurological work restrictions as a result of the accident. *Id*. With regard to the etiology of Claimant's lumbar spine complaints, Dr. Herskowitz reiterated that he did not believe the accident was related in any way. *Id*. He further stated that "[Claimant] has had previous injuries to his back and had complaints in the records ongoing of back pain in the past and this may be a combination of injuries at his work and getting older." *Id*. With regard to the etiology of Claimant's pain in the lower extremities, Dr. Herskowitz maintained that these were "entirely subjective" complaints and that "people with diabetes can have complaints of pain, what we call neuralgia neuritis, but other than that, it's subjective [and could not be verified]." *Id*. at 168.

Finally, I will turn to the opinion of Dr. Millheiser, the board-certified orthopedic surgeon who testified on behalf of Employer. Dr. Millheiser testified that Claimant had severe intermittent pains, which were sharp in the low back and left great toe. EX 19:12. The back pain

radiated down the left leg and there was numbness and weakness in the left lower extremity. *Id*. The back pain was increased with bending, lifting, twisting, walking, sitting, standing and sleeping. *Id*. Claimant would fall because of left leg weakness. *Id*. He had pain in the left foot with standing fifteen (15) to twenty (20) minutes and walking a quarter of a block. *Id*. He experienced pain when moving the toes and his toe would swell at times. *Id*. He did not use any support other than a cane and had not worked since about May 2001. *Id*.

Dr. Millheiser performed a standard examination of the back, foot, and toe. He recorded Claimant's height and weight and noted that Claimant appeared to be "in no acute distress." *Id*. at 17. He noted that Claimant walked with a flat foot gait and used a cane in his left hand. *Id*. With regard to the back, he noted that there was no lumbar tenderness and he had full range of motion in the lumbar spine. *Id*. There was no spasm, list, tilt or scoliosis. *Id*. He was not using a support. *Id*. Dr. Millheiser further testified that Claimant was not limping and there was no atrophy in the lower extremity. *Id*. at 18. There was no global hypesthesia or numbness of the entire left lower extremity, and hypesthesia of the right lower extremity from the knee distally. *Id*. There was giving away weakness in the left lower extremity. *Id*. He also found that there was no numbness in the hand and that the knee and ankle reflex were equal and intact. *Id*. A straight leg raising test was negative sitting and positive at about twenty (20) degrees on the left and forty five (45) degrees on the right. *Id*. Dr. Millheiser testified that there were various signs of over-exaggeration, including disparate straight leg raising, double thigh flexion and Patrick signs. *Id*. He testified that lumbar lordosis was normal and there were no trigger points. *Id*.

With respect to the left great toe, Dr. Millheiser noted a well-healed scar and that the "skin was shining." *Id*. He stated that the toe lacked ten (10) degrees of plantar flexion at the MP joint. *Id*. There was no motion at the interphalangeal (IP) joint. *Id*. He had some mild toe tenderness. *Id*. X-rays showed a fusion of the IP joint of the big toe. *Id*. at 19. There was only one IP joint in the big toe as compared to the other toes. *Id*. There were some minimal degenerative changes at the metatarsal phalangeal (MP) joint. *Id*. The lumbar spine was unremarkable. *Id*.

In terms of the orthopedic significance of the findings of his back exam, he found that there were "really no objective signs of injury." *Id*. Dr. Millheiser further stated that there was a considerable amount of over-exaggeration. *Id*. The global hypesthesia of the left lower extremity was not an objective finding (i.e. there is no anatomic lesion that produces that). *Id*. With regard to the right lower extremity, Dr. Millheiser noted that Claimant had hypesthesia from the knee down. *Id*. He testified that in a case of diabetic neuropathy, Claimant should have demonstrated some hypesthesia in the hands, and there was none. *Id*. On cross examination, Dr. Millheiser stated that his opinion that Claimant did not suffer from diabetic neuropathy was grounded in part on the fact there were no similar findings in the hands. *Id*. at 52. He further stated that diabetic neuropathy is "usually quite symmetrical" and that it "may vary a little, but it doesn't involve the entire left lower extremity." *Id*. Dr. Millheiser then stated that Claimant had numbness all the way up to the high thigh area on one side and the knee on the other side. *Id*.

Dr. Millheiser also testified that there was giving way weakness in the left lower extremity. *Id*. at 19-20. Again, however, that was not an objective finding but rather over-exaggeration and lack of cooperation, according to Dr. Millheiser. *Id*. The straight leg raising test was negative sitting, and positive lying down with twenty eight (28) degrees on the left and

forty five (45) degrees on the right when he was supine for lying down. *Id*. at 20. Dr. Millheiser explained, however, that "[if the test] is negative sitting, it should be positive when someone's lying down. It's the exact same test. Except when they're sitting, you do not ask them does it hurt. When they're lying down, you say does this hurt. So if it doesn't hurt in a sitting position, it shouldn't hurt lying down." *Id*. He further testified that the double thigh flexion and Patrick signs should not cause pain in the back. *Id*. He stated that flexion hips and knees relieves back pain rather than increasing it and that Patrick sign have nothing to do with the back but are rather a test for hepatology. *Id*. Therefore, Dr. Millheiser deduced that there was considerable exaggeration in the back exam. *Id*.

In sum, Dr. Millheiser opined that Claimant did not have a permanent back injury as a result of the March 22, 2001 accident. *Id*. at 22-23, 48-49. When questioned as to whether there was any correlation between Claimant's back pain and the March 22, 2001 accident, he responded that he had not looked at the medical records (to which he would defer), that he was not present at the time of the accident, and that he would therefore give Claimant "the benefit of the doubt." *Id*. at 22. On the other hand, however, Dr. Millheiser stated: "I mean if the man complained of back pain and he was treating for back strain [sic], I don't have any problem with that. What my concern here is, is that is there any residual problem or impairment from his back complaints, and I didn't find any." *Id*. Dr. Millheiser testified that he did not believe Claimant required any further medical treatment. *Id*. at 23. He further stated that, as far as being a longshoreman, there was no reason that, from an orthopedic standpoint, Claimant would have any physical work restrictions or limitations to work.[55] *Id*.

In weighing the opinions of Drs. Galitz, Kohrman, Herskowitz, and Millheiser, I conclude that Claimant has failed to prove that the March 22, 2001 accident caused his lumbar spine injury or aggravated any pre-existing injury. Dr. Galitz's opinion in this regard is entitled to very little weight, since he is a foot surgeon and has limited expertise on the lumbar spine. Moreover, as noted above, his opinion lacks specificity and provides mere possibilities as to what could be causing Claimant's lumbar spine injury. While Dr. Kohrman is better qualified to testify about Claimant's lumbar spine injury, his opinion is similarly unpersuasive. In sum, he testified that Claimant could have experienced direct trauma to his back through a startled response or could have experienced abnormal lumbar biomechanics due to his orthopedic injury. However, as noted previously, the description of Claimant's March 22, 2001 accident does not support Dr. Kohrman's startled response theory, since Claimant never actually told Dr. Kohrman that he was jolted or jarred at the time of the accident. Furthermore, in testifying that Claimant may have experienced abnormal lumbar biomechanics due to his orthopedic injury, Dr. Kohrman merely recites what can theoretically happen in accidents such as the one Claimant experienced. In the end, Dr. Kohrman suggested that a nerve conducted EMG and lumbar spine MRI would best determine the source of Claimant's injuries in this regard; however, no such objective

[55] On cross examination, Dr. Millheiser explained that his finding that Claimant suffered a permanent impairment with regard to his toe was not inconsistent with his finding that Claimant had absolutely no work restrictions whatsoever. EX 19:49. Because Claimant's permanent impairment involved the IP joint of the toe, he had no restrictions as far as walking, standing, bending, lifting, twisting, or any other reasonable activity that a longshoreman might do. *Id*.

evidence exists in the record. As a result, Claimant's physicians simply postulate and fail to testify with medical certainty as to the cause of Claimant's lumbar spine injury.

By contrast, the opinion of Dr. Herskowitz is well reasoned in that the description of the accident that he obtained from Claimant supports his belief that the March 22, 2001 accident is in no way related to Claimant's lumbar spine injury. Specifically, Claimant never mentioned any fall to the ground to Dr. Herskowitz. Moreover, Dr. Herskowitz noted that Claimant did not mention any pain in his lumbar spine until four (4) or five (5) months after the accident. This bolsters his opinion that Claimant did not experience any direct trauma to the back at the time of the accident. In terms of neurological impairment, Dr. Herskowitz found that there was no objective evidence in this regard. While he was inclined to give Claimant "the benefit of the doubt", the results of his examinations demonstrated that Claimant was likely exaggerating his neurologic symptoms. In a similar vein, Dr. Millheiser testified that there was no objective evidence of Claimant's lumbar spine or neurologic impairment.

Aggravation of Underlying Diabetic Condition and Diabetic Retinopathy Claim

The Claimant's position is that the March 22, 2001 accident resulted in an aggravation of his underlying diabetic condition requiring the administration of additional medications. *Claimant's Brief* at 23. Additionally, Claimant asserts that the aggravation of his underlying diabetic condition resulted in "a severe case of diabetic retinopathy, requiring three surgical procedures and resulting in complete blindness in the right eye and severe vision loss in the left eye." *Id*. Thus, Claimant's diabetic retinopathy claim is founded in large part on his assertion that the accident aggravated his underlying diabetic condition.

I will first assess Claimant's argument that the accident aggravated his underlying diabetic condition, since it provides a substantial foundation for his diabetic retinopathy claim. To establish a *prima facie* claim of diabetes mellitus, an aggravation of his underlying diabetic condition, Claimant need only show that he sustained physical harm or pain and that an accident occurred in the course of his employment or conditions existed at work, which could have caused, aggravated or accelerated his harm or pain. The aggravation rule provides that if an employment injury aggravates, accelerates, exacerbates, contributes to or combines with a previous infirmity, disease, or underlying condition, the employer is liable for compensation for, not just the disability resulting from the employment injury, but instead, for the employee's total resulting disability. ***Strachan Shipping Co. v. Nash***, 782 F.2d 513, 517 (5th Cir. 1986); ***Independent Stevedore Co. v. O'Leary***, 357 F.2d 812 (9th Cir. 1966). The Claimant is able to satisfy his *prima facie* burden easily through the testimony of his treating physician, Dr. Pardell, and even through the testimony of Dr. Cohen, the endocrinologist who testified on behalf of the Employer. Both of these physicians testified to the effect that stressful accidents, such as the one undergone by Claimant, can potentially affect diabetic control. *See* CX 2:10-11; EX 22:24-26.

Since the Claimant has established a *prima facie* claim of diabetes mellitus, he is entitled to the statutory presumption under Section 20(a). The burden now shifts to the Employer to establish that the Claimant's underlying diabetic condition was not aggravated by the accident. The relevant inquiry here is whether the Employer has succeeded in establishing the lack of a

causal nexus. To that end, the Employer provided evidence, through the testimony of Dr. Cohen, that Claimant exhibited poor control of his diabetes long before the accident, that Claimant ironically demonstrated better control of his diabetes after the accident, and that any connection between the accident and any dyscontrol of his diabetes experienced post-accident could be based only speculatively, at best, on a causal connection. EX 22:5, 7, 24-26, 30-32. Accordingly, I find that the Employer has met its burden to provide substantial evidence severing the causal link.

Since the Section 20(a) presumption has been rebutted and no longer controls, the record as a whole must be evaluated. The qualifications of each physician must factor into a determination of how much weight to accord each opinion. In addition, when an injured employee seeks benefits under the Longshore and Harbor Workers' Compensation Act (LHWCA), a treating physician's opinion is entitled to "special" weight. ***Amos v. Director, Office of Workers' Compensation Programs***, 153 F.3d 1051 (9th Cir., 1998); *See also*, ***American Stevedoring Ltd. v. Marinelli***, 248 F.3d 54, (2nd Cir., 2001)***; Lozada v. Director, Office of Workers' Compensation Programs***, U.S. Dept. of 1991 A.M.C. 303 C.A.2,1990; Longshore and Harbor Workers' Compensation Act, §§ 1 et seq.[56] The opinion of Dr. Pardell, Claimant's treating physician for diabetes, is entitled to this special weight. However, the opinion of Dr. Cohen, the endocrinologist who testified on behalf of Employer, is also entitled to added weight, since he is an endocrinologist whereas Dr. Pardell is not. In that sense, the opinions of Drs. Pardell and Cohen are entitled to equal weight. In addition to the importance of the physicians' qualifications, I also note the foundational significance of a well-reasoned and well-documented medical opinion. ***Clark v. Karst-Robbins Coal C***o., 12 B.L.R. 1-149 (1989) (*en banc*). *See also* ***Mabe v. Bishop Coal Co.***, 9 B.L.R. 1-67 (1986) (a report which is internally inconsistent and inadequately reasoned may be entitled to little probative value).[57]

I must now turn to the substance of these medical opinions. In comparing Claimant's diabetic control before and after the accident, Dr. Pardell essentially compared two blood sugar readings. The first reading, taken before the accident on November 24, 2000, indicated good control, assuming it was taken postprandial. CX 2:7. The second reading, taken after the accident on May 9, 2001, indicated poor control. *Id*. at 8. The implication here was that Claimant maintained "good control" before the accident and "poor control" after the accident; however, on cross examination, Dr. Pardell admitted that prior to his treating patient, there were instances where Claimant's diabetes was out of control. *Id*. at 21. Nevertheless, in conjunction with the idea that the accident contributed to Claimant's dyscontrol of diabetes, Dr. Pardell set forth the general notion, based on his review of the current medical literature, that "any stressful condition" will affect diabetic control. *Id*. at 10-11. Moreover, he asserted that the effect of stress on diabetic control can in turn aggravate the secondary effects of diabetes. *Id*. at 12. He stated that "every organ system is affected by dyscontrol of diabetes." *Id*. When specifically questioned as to whether his chart documented an aggravation of Claimant's diabetic condition with respect to the March 22, 2001 accident, Dr. Pardell's response was equivocal. He testified:

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[56] In ***Pietrunti v. Director, Office of Workers' Compensation Programs***, 119 F.3d 1035 (2nd Cir., 1997) an ALJ's findings were reversed by the court because he failed to attribute "great" weight to the opinion of a treating physician.

[57] Although these are cases under the Black Lung Benefis Act, their application is the same.

"Well, the time – from the time [the Claimant] saw me his sugars were abnormal. Now, if he had a normal sugar before, I could only say that the sugar before is normal and the sugar afterwards is abnormal if – if there is an intervening stress factor that could be considered a cause – a causative factor." *Id*. at 13. Finally, Dr. Pardell noted on cross examination that Claimant's current medications differed from those that he was taking at the time he first saw Claimant in that Avandia was added to his regimen. *Id*. at 24. Dr. Pardell testified that Avandia is "a more recent approach to control diabetics on oral hypoglycemics." *Id*.

I do not find the opinion of Dr. Pardell well reasoned. In attempting to demonstrate that Claimant developed dyscontrol of diabetes after the accident, Dr. Pardell merely compares one blood sugar reading before the accident with one blood sugar reading after the accident. Not only is such a narrow comparison unpersuasive, but Dr. Pardell further admitted on cross examination that there were times prior to his treating Claimant where he exhibited dyscontrol. Thus, the shortcoming of such a narrow comparison is actually revealed through Dr. Pardell's very own testimony on cross examination. In addition, when questioned specifically as to whether the accident was a "causative factor", Dr. Pardell's testimony was equivocal and vague. He stated that from the time he first saw Claimant, his blood sugars were abnormal. He then stated that "if he had a normal sugar before, I could only say that the sugar before is normal and the sugar afterwards is abnormal if – if there is an intervening stress factor that could be considered a cause – a causative factor." Not only does this statement make very little sense, but its apparent significance is also undercut by Dr. Pardell's own testimony. Dr. Pardell began his statement with "if he had a normal sugar [before the accident]", yet Dr. Pardell admitted on cross examination that there were times prior to his treating Claimant where he exhibited dyscontrol. In this context, Dr. Pardell's general assertion that "any stressful condition" will affect diabetic control has very little probative value.

By contrast, I find the opinion of Dr. Cohen well reasoned. Dr. Cohen testified that Claimant had been demonstrating "good control" of his diabetes since the March 22, 2001 accident, but that based on his review of the medical records, Claimant demonstrated poor control of his diabetes in the past, even at the time of his 1988 accident. EX 22:19. He further explained that out-of-control diabetics have "blood sugars that are good and bad" such that "a single blood sugar reading is really not germane. It's a meaningless piece of information." Id. at 37. Neither a single blood sugar reading that is very high nor a single blood sugar level that is very low would be dispositive of one's overall control. Unlike Dr. Pardell who simply compared one blood sugar reading before the accident and one blood sugar reading after the accident, Dr. Cohen testified as to the entire set of medical records as a whole. As a result, I find Dr. Cohen's opinion regarding Claimant's longstanding dyscontrol of diabetes before the accident more persuasive than Dr. Pardell's cursory comparison.

With regard to whether the March 22, 2001 accident aggravated Claimant's diabetic condition, Dr. Cohen's response was more nuanced than that of Dr. Pardell. He stated that one's environment is a "big factor" in the control of blood sugar and that stress increases the need for insulin, which can make diabetes more difficult to control. *Id*. at 24-26. Thus, in the aftermath of a stressful situation, a "fender-bender car accident" for example, a diabetic may require supplemental medication for "a couple of days" to regulate blood sugar control. *Id*. However, the need for supplemental medication "goes away" after that, and the diabetic's condition returns

to the way it was before the stress. *Id*. Thus, according to Dr. Cohen, it seems that stress has only a temporary affect on blood sugar control and can be regulated with supplemental medication. Dr. Cohen testified that Claimant may need more medication to remedy any exacerbation of his diabetes that may have resulted from the accident. *Id*. at 26. He also indicated that Claimant, as a Type II diabetic, was eventually going to require insulin, the accident notwithstanding. *Id*. While it was possible that Claimant would require insulin sooner in life on account of being inactive and in chronic pain, it was not the accident that caused this problem. *Id*. at 26-27. Dr. Cohen further reiterated that Claimant exhibited poor control of his diabetes long before the March 22, 2001 accident, and that he was a poorly controlled diabetic even at the time of the original accident in 1988. *Id*. at 19.

Significantly, Dr. Cohen did not rule out the possibility that the March 22, 2001 accident aggravated Claimant's diabetic condition by stating that stress increases the need for insulin, which can make diabetes more difficult to control. He also admitted that Claimant "may need more medication to remedy any exacerbation of his diabetes that may have resulted from the accident." *Id*. at 26. However, Dr. Cohen did not state definitively that the accident contributed to any dyscontrol of diabetes that Claimant may have experienced after the accident. I note that, while Dr. Cohen's opinion does not rule out the possibility of the accident having aggravated Claimant's underlying diabetic condition, it does not affirmatively draw that causal connection. Dr. Cohen's testimony can be characterized as speculative, at best, with regard to whether there is such a causal connection, noting it only as a possibility. Accordingly, I conclude that Claimant has failed to prove that the accident aggravated his underlying diabetic condition. Burden of proof.

I must now turn to Claimant's related diabetic retinopathy claim. As noted above, Claimant's diabetic retinopathy claim is largely based on his claim that the accident aggravated his underlying diabetic condition. Having already concluded that the Claimant failed to establish any link between an aggravation of his underlying diabetic condition to the accident, I note that his diabetic retinopathy claim is thereby substantially weakened. Nevertheless, I will evaluate Claimant's assertion that the work-related accident, and the pain, stress, inactivity, and surgery, associated therewith, aggravated his underlying diabetic condition, which in turn accelerated the secondary effects of his diabetes, including his diabetic retinopathy. *See Claimant's Brief* at 23. Specifically, the Claimant argues that the March 22, 2001 crush injury resulted in "a severe case of proliferative diabetic retinopathy, requiring three surgical procedures and resulting in complete blindness in the right eye and severe vision loss in the left eye." *Claimant's Brief* at 23. To establish a *prima facie* claim of diabetic retinopathy, Claimant need only show that he sustained physical harm or pain and that an accident occurred in the course of his employment or conditions existed at work, which could have caused, aggravated or accelerated his harm or pain. The aggravation rule provides that if an employment injury aggravates, accelerates, exacerbates, contributes to or combines with a previous infirmity, disease, or underlying condition, the employer is liable for compensation for, not just the disability resulting from the employment injury, but instead, for the employee's total resulting disability. ***Strachan Shipping Co. v. Nash***, 782 F.2d 513, 517 (5th Cir. 1986); ***Independent Stevedore Co. v. O'Leary***, 357 F.2d 812 (9th Cir. 1966).

The Claimant is able to satisfy his *prima facie* burden through the testimony of Dr. Hamburger, who provided the following assertions: (1) when blood sugar goes out of control, the risk of developing retinopathy or bleeding in the eye increases; (2) physical stress, illness and surgery all affect blood sugar; and (3) the stress of surgery exacerbates the metabolic abnormalities of diabetes mellitus. CX 3:12-13. He testified that it was possible for diabetic patients to go from having no retinopathy (or minimal retinopathy) to developing severe retinopathy in approximately six (6) months. *Id*. at 15-16. Based on this possibility, he opined that Claimant could have developed severe diabetic retinopathy in the six (6) month period that elapsed between the March 22, 2001 accident and the onset of Claimant's severe diabetic retinopathy in September 2001. *Id*. at 16. He stated that Claimant could have gone "from minimal background diabetic retinopathy with a few little dot hemorrhages scattered around which was not really affecting his vision in any way to this type of proliferative diabetic retinopathy if his blood sugar was high and out of control." *Id*. I conclude that Claimant has established a *prima facie* claim of diabetic retinopathy based on Dr. Hamburger's testimony. This testimony demonstrates that Claimant suffers from physical harm and that the accident *could* have aggravated or accelerated Claimant's condition. Accordingly, Claimant is entitled to the statutory presumption under Section 20(a).

The burden now shifts to the Employer to establish that Claimant's underlying diabetic retinopathy was not accelerated by the accident. The relevant inquiry here is whether the Employer has succeeded in establishing the lack of a causal nexus. To that end, the Employer provides the testimony of Dr. Trattler. Dr. Trattler pointed to a Bascom Palmer medical record dated December 23, 1996, documenting that Claimant had begun to develop diabetic retinopathy well before the March 22, 2001 accident. EX 21:10. The medical record stated that Claimant had "DM" (i.e. diabetes mellitus) and "mild BDR" (i.e. background diabetic retinopathy). *Id*. It further stated that Claimant had diabetes in the retina. *Id*. at 10-11. Dr. Trattler then pointed to a medical record dated August 21, 2000, which also showed that Claimant had begun to develop diabetic retinopathy well before the March 22, 2001 accident. *Id*. at 12. This medical record stated that Claimant had "a lot of changes in the retina," which Dr. Trattler testified were typical for progressive diabetic retinopathy. *Id*. At this time, laser therapy was recommended to stop the progression of retinopathy; however, Claimant did not undergo this therapy until September 2001, approximately thirteen (13) months later. *Id*. at 12-13, 15. Dr. Trattler testified that if a diabetic receives no treatment, as was the case with Claimant for approximately thirteen (13) months, then the risk of going blind is seventy five (75) percent.[58] *Id*. at 13.

Dr. Trattler testified that Claimant's diabetic retinopathy could have been improved had he undergone earlier intervention with laser. *Id*. at 24. The changes that Claimant underwent reflect changes that are seen in diabetics who go untreated. *Id*. Dr. Trattler stated that he did not believe the March 22, 2001 accident had any "direct bearing" on Claimant's proliferative retinal diabetic changes. *Id*. at 24-25. He further testified that at Claimant's stage of retinal vascular disease, control of blood sugar was not the major factor. *Id*. Rather, specifically controlling the ischemia and the proliferation with laser is what would have potentially stopped the progress of the diabetic retinopathy. *Id*. To that end, Dr. Trattler testified that "even with the most perfect of treatments … [there is still] a twenty five (25) percent chance" that a patient such as Claimant

[58] Treatment reduces the risk of going blind from seventy five (75) percent to twenty five (25) percent.

will go blind. *Id*. at 25. As a result, he did not agree that the March 22, 2001 accident or Claimant's subsequent toe surgery accelerated the proliferative diabetic retinopathy. *Id*. at 31. Instead, Dr. Trattler pointed to Claimant's fifteen (15) year history of abnormal blood vessels that had been damaged from the disease, and the fact that by August 2000, Claimant was "already getting in major trouble." *Id*. at 29-31.

To rebut the Section 20(a) presumption, Employer's burden is to present substantial evidence that Claimant's diabetic retinopathy was not accelerated by the accident. Dr. Trattler testified to the effect that the accident had no direct bearing on Claimant's proliferative retinal changes. He further stated at Claimant's stage of retinal vascular disease, blood sugar was not the major factor in controlling the proliferative retinal diabetic changes; rather, controlling the proliferation with laser is what would have potentially stopped the progress of the diabetic retinopathy. He emphasized that by August 2000, Claimant was "already getting in major trouble" with regard to proliferative retinal diabetic changes. In sum, through the testimony of Dr. Trattler, the Employer has introduced unequivocal testimony that severs the relationship between the acceleration of Claimant's diabetic retinopathy and the accident. This is sufficient to rebut the Section 20(a) presumption. In addition, though not required at this stage of the burden-shifting analysis, the Employer has provided another agency of acceleration, namely Claimant's failure to undergo laser surgery in August 2000, to sever the link between acceleration of Claimant's diabetic retinopathy and the accident. Based on the testimony of Dr. Trattler, I conclude that Employer has rebutted the Section 20(a) presumption.

Since the Section 20(a) presumption has been rebutted and no longer controls, the record as a whole must be evaluated. The qualifications of each physician must factor into a determination of how much weight to accord each opinion. In this regard, I note that both Drs. Hamburger and Trattler are board certified opthalmologists and spent time with Claimant in an equal capacity. Thus, I find that their opinions are entitled to equal weight. I must now to turn to the substance of these medical opinions. While Dr. Hamburger testified that Claimant could have developed diabetic retinopathy in six (6) months, he also stated that it could have started developing before the March 22, 2001 accident. Specifically, there could have been early proliferative stages developing prior to March 22, 2001, and if Claimant's blood sugar went out of control after that, the proliferative changes would have rapidly accelerated and become worse and more aggressive. Although he could not identify when the whole process started, he opined that Claimant "probably had some background retinopathy changes with mild bleeding for a long time." On the issue of what precisely caused Claimant's diabetes to become out of control, Dr. Hamburger stated that he would have to defer to a diabetes specialist, since such an analysis was more within the realm of an endocrinologist. He admitted, moreover, that he did not know about the state of Claimant's blood sugar control before the accident, and that it would be difficult to precisely pinpoint in time the stages of Claimant's problem. He could testify with certainty only that Claimant was proliferative when he was seen by Dr. Loo in September 2001 and that his vision problems began sometime in July 2001.

By contrast, Dr. Trattler demonstrated a keen awareness of Claimant's medical history and how this medical history factored into the development of Claimant's diabetic retinopathy. He pointed specifically to a medical record dating back as early as December 1996, which showed that Claimant had started developing background diabetic retinopathy well before the

March 22, 2001 accident. In addition, he pointed to a medical record dated August 21, 2000, documenting that Claimant was developing "a lot of changes in the retina." Significantly, Claimant was urged at this time to undergo laser therapy to stop the progression of his retinopathy; however, he declined to do so until September 2001, approximately thirteen (13) months later. Dr. Trattler contended that it was Claimant's negligence in failing to undergo surgery in August 2000, and not any aggravation of his diabetic condition that he may have experienced from the March 22, 2001 accident, that was responsible for the current state of his diabetic retinopathy.

In weighing the opinions of Drs. Hamburger and Trattler against each other, I conclude that Dr. Trattler's opinion is better reasoned than that of Dr. Hamburger. Dr. Hamburger admitted that he was unaware of the state of Claimant's blood sugar before the accident, and that he would in any event defer to an endocrinologist regarding what caused Claimant's dyscontrol of diabetes. He provided several general assertions, such as the notion that when blood sugar goes out of control, the risk of developing diabetic retinopathy increases. However, such a general assertion is hardly probative of Claimant's specific medical situation, especially given that Dr. Hamburger admitted limited knowledge of Claimant's blood sugar history before the accident. Dr. Hamburger also testified that, in general, physical stress, illness, and surgery all affect blood sugar, and that the stress of surgery exacerbates the metabolic abnormalities of diabetes mellitus. Again, however, he failed to apply this generality with any medical certainty to Claimant's specific medical situation. Dr. Trattler, by contrast, demonstrated a keen awareness of Claimant's medical history and how this medical history factored into the development of his diabetic retinopathy. He testified with specificity that it was Claimant's negligence in failing to undergo surgery in August 2000, and not any aggravation of his diabetic condition that he may have experienced from the March 22, 2001 accident, that was responsible for the current state of his retinopathy. Moreover, Dr. Trattler's opinion that the accident did not aggravate Claimant's diabetic retinopathy is consistent with the opinion of Dr. Cohen, who is best qualified on the issue of aggravation or exacerbation of diabetes. Accordingly, I conclude that the Employer must prevail on the issue of diabetic retinopathy.

Psychiatric Claim

Finally, Claimant posits that "as a direct and proximate cause of the March 22, 2001 crush injury and resulting pain, he has become depressed and requires psychiatric care and treatment." *Claimant's Brief* at 21. To establish a *prima facie* claim of depression, Claimant need only show that he sustained physical harm or pain and that an accident occurred in the course of his employment or conditions existed at work, which could have caused, aggravated or accelerated his harm or pain. To that end, Dr. Garcia-Grande diagnosed Claimant with depressive disorder primarily due to his concerns about his left foot and back pain, and the fact he was no longer able to work as a longshoreman. CX 5:10-11. The evaluations undertaken by Dr. Garcia-Grande were at the referral of Claimant's attorney. I note that Dr. Garcia-Grande establishes a link between Claimant's depression and the accident by relying on Claimant's other alleged injuries, many of which I have already concluded were not linked to the accident. Nevertheless, since Dr. Garcia-Grande cites foot pain as one reason for Claimant's depression, and the Employer is unequivocally liable for this injury, I will accept Dr. Garcia-Grande's

testimony for purposes of establishing a *prima facie* claim. Since the Claimant has established a *prima facie* claim of depression, he is entitled to the statutory presumption under Section 20(a).

The burden now shifts to the Employer to establish that the Claimant's depression was not caused by the accident. The relevant inquiry here is whether the Employer has succeeded in establishing the lack of a causal nexus. To that end, the Employer provided the testimony of Dr. Castiello, who opined that Claimant did posses a severe personality disorder, though not depression, and that this disorder was present prior to the toe injury. EX 20:17, 29. Specifically, Dr. Castiello opined that Claimant's psychological disorder stemmed from the fact that he tended to link his problems to litigation. *Id*. at 17. Thus, not only did Dr. Castiello disagree that Claimant's psychiatric problem was caused by the accident, he further opined, based on his mental status evaluation, that Claimant did not suffer from depression. I conclude that Dr. Castiello's testimony is sufficient to rebut the Section 20(a) presumption.

Since the Section 20(a) presumption has been rebutted and no longer controls, the record as a whole must be analyzed. The qualifications of each physician must factor into a determination of how much weight to accord each opinion. In this regard, I note that both Drs. Garcia-Grande and Castiello are board certified psychologists. Although Dr. Garcia-Grande saw Claimant twice and Dr. Castiello saw Claimant only once, I do not find that one extra visit renders Dr. Garcia-Grande better qualified to testify about Claimant's psychiatric state. Accordingly, I conclude that the opinions of Drs. Garcia-Grande and Castiello are entitled to equal weight. I must now turn to the substance of these medical opinions. In that regard, Dr. Garcia-Grande performed two mental status examinations on Claimant. The first mental status examination showed Claimant to be very depressed; his speech was soft and slow, he had very little facial expression, a short attention span, and a very low self-image and self-worth. CX 5:9-10. Other than that, the rest of the exam was negative, meaning that Claimant was oriented, knew where he was, knew his name, and knew the date; there were no hallucinations and nothing psychotic. *Id*. Claimant did not appear to be a danger to himself and was not acutely suicidal, though he did demonstrate symptoms of severe depression. *Id*. Dr. Garcia-Grande's diagnostic impression was that Claimant had a severe depressive disorder, which was primarily due to his concerns about his left foot and back pain, and the fact he was no longer able to work as a longshoreman. *Id*. at 10-11. In rating Claimant's general functionality on a scale of zero (0) to one hundred (100), Dr. Garcia-Grande rated Claimant at a fifty (50), which connoted serious symptoms. *Id*. at 10. Based on the first mental status examination, Dr. Garcia-Grande recommended psychiatric treatment. *Id*. at 11-12.

Dr. Garcia-Grande performed his second mental examination of Claimant over a year later at which point Claimant had not received any recommended psychiatric treatment. *Id*. at 12. Although the second mental examination produced similar results, Dr. Garcia-Grande noted that Claimant seemed to have deteriorated somewhat and was having more difficulty with memory and concentration. *Id*. at 15. Dr. Garcia-Grande testified, however, that it would be too speculative to assume that Claimant's condition had deteriorated because he did not receive any psychiatric care. *Id*. at 17. He again recommended psychiatric treatment but noted that because Claimant's symptoms appeared "chronic", the results of therapy would "probably not be very positive." *Id*. at 15. Dr. Garcia-Grande testified that from a psychiatric standpoint, due to the severity of Claimant's condition, he did not think that he was capable of working in any capacity

as of September 10, 2003. *Id*. at 16. He had similarly opined that Claimant was not capable of working due to the severity of his depression at the first consultation on June 4, 2002. *Id*. With regard to which aspects of his severe depression would preclude Claimant from working, Dr. Garcia-Grande testified that Claimant's severe depressive mood "does not allow him to concentrate or stay attentive to any task that he would perform in any kind of work. *Id*. at 17. He is focused on pain and is constantly worrying about his pain, the future, and crying spells. *Id*.

By contrast, Dr. Castiello performed a mental status examination of Claimant from which he drew a very different interpretation than that of Dr. Garcia-Grande. Dr. Castiello observed that Claimant maintained a socially acceptable appearance, seemed not to need the cane which he carried with him, and appeared very guarded by carefully considering every question before offering an answer or an explanation. EX 20:14. He noted that at times, Claimant would often become tangential and did not answer certain questions, while at other times, he was very open, explicit, and clear. *Id*. He noted that Claimant had the capacity to do so at will and that he was fully oriented and knew where he was and why. *Id*. Claimant denied having symptoms of an active mental disorder and expressed the opinion that he just wanted to return to the way of life he had prior to the accident, including health issues. *Id*. at 15. He "wanted to be in a situation where he didn't have any more high blood pressure, the diabetes was under control, recovery in the eyesight he had lost to the right eye, and having no pains or numbness." *Id*. Dr. Castiello assessed that "[i]n general, [Claimant] appeared to be functioning at an average intellectual capacity" and that there was "no inability to form rational concepts." *Id*. Dr. Castiello noted that Claimant "appeared quite bland" and that there were certain moments where he seemed to cry in an attempt to dramatize a comment he was making. *Id*. at 15-16. Claimant responded in a very "non-spontaneous manner." *Id*. at 16. Dr. Castiello did not think that his ability to recognize reality was impaired as Claimant did not say anything to indicate that he had been isolated from reality. *Id*. Claimant seemed to have "a clear tendency to look at things in his own way, perceptions" and "did not appear to have the best of judgment and the capacity or the ability to develop insight into situations based on factual information." *Id*.

Dr. Castiello opined that Claimant was manifesting elements of severe personality disorder. *Id*. at 17. Specifically, Claimant had maintained an element of adjustment for life according to his personality and outlook on life. *Id*. Those personality characteristics were being manifested in connection with the present situation (i.e. the litigation). *Id*. Dr. Castiello testified that Claimant's exposure to litigation in the past as a result of his 1988 injury was significant because it demonstrated Claimant's familiarity with the process of litigation. *Id*. at 18. He opined that Claimant did not have any interest in any form of psychiatric treatment because Claimant made very clear that his problems were related to his pain, the numbness, high blood pressure, control of the diabetes, and eyesight deterioration. *Id*. at 21. Dr. Castiello stated that credibility is a factor in making a proper diagnosis, and that Claimant appeared opinionated, uncritical, self-serving in most of his presentations concerning the accident.[59] *Id*. at 22-23. On cross examination, Dr. Castiello admitted that, while he did not doubt the sincerity of Claimant

[59] Dr. Castiello later clarified that by self-serving he meant: "[Claimant] does have serious medical problems … but that is not the way he sees it. He knows he has some medical problems, but the emphasis on his part is to link it all to the litigation, link it all to the problem of litigation and nothing else. That is self-serving." EX 20:49.

with respect to his symptoms, he did doubt his sincerity with respect to how the symptoms developed and when and where. *Id*. at 30.

In weighing the opinions of Drs. Garcia-Grande and Castiello against each other, I note that they both detected, to some extent, that Claimant was preoccupied with his physical injuries. Dr. Garcia-Grande based his diagnosis of depression on these physical injuries, opining that Claimant was depressed due to his left foot and back pain and inability to work as a longshoreman. Dr. Castiello also noted Claimant's desire to be in a situation where he no longer had myriad health problems, including high blood pressure, diabetes, loss of eyesight, and pain and numbness. However, Dr. Castiello did not conclude that Claimant was depressed on account of these problems. Rather, he emphasized that Claimant denied having symptoms of an active mental disorder. He further opined that rather than depression, Claimant's psychological problem stemmed from his tendency to link his problems to litigation. In sum, the conflict between the opinions of Drs. Garcia-Grande and Castiello amounts to differing subjective interpretations of the same symptoms. Both physicians observed that Claimant appeared bland and had little facial expression but was otherwise oriented and had the ability to form rational concepts. While Dr. Garcia-Grande interpreted Claimant's demeanor as showing signs of depression, Dr. Castiello opined that Claimant was responding to the fact that he was involved in litigation and dramatizing his situation.

Overall, I find Dr. Garcia-Grande's opinion better reasoned in that his logic (i.e. his basis for diagnosing depression from the symptoms he observed) is easier to follow and more thoroughly explained than that of Dr. Castiello. However, Dr. Garcia-Grande's diagnosis relies rather problematically on certain physical injuries that I have already concluded are not linked to the accident. Specifically, he opined that Claimant's depressive disorder was primarily due to his concerns about his left foot and back pain, and the fact he was no longer able to work as a longshoreman. While I concluded that Claimant's left foot injury was causally connected to the accident, I have concluded that his back pain was not linked to the accident. In addition, I concluded that Claimant's inability to work as a longshoreman, due primarily to his diabetic retinopathy, was not linked to the accident. As Dr. Garcia-Grande's diagnosis assumes that Claimant's depression stems from a combination of all of his physical injuries, it is difficult to parse out the extent to which each injury contributes to his depression. Significantly, it is not possible to discern how much of Claimant's depression is caused by his toe injury alone, the only injury that Claimant has successfully linked to the March 22, 2001 accident. It seems, however, based on all of the medical opinions regarding Claimant's toe injury that the toe injury is only minimally responsible for Claimant's current pain and inactivity, which would make it minimally responsible, if at all responsible, for his depression. Therefore, I conclude that Claimant has failed to meet his burden of proof with regard to his psychiatric claim.

ORDER

Based upon the foregoing findings of fact, conclusions of law, and upon the entire record, I enter the following **ORDER**:

1. Employer/Carrier shall pay Claimant compensation for temporary total disability from March 23, 2001 through April 5, 2001 and from June 5, 2001 through February 26, 2002, based on an average weekly wage of $1082.50, in accordance with the provisions of Section 8(b) of the Act. 33 U.S.C. § 908(b). The impairment ratings to be used in this calculation, as reflected in this Decision and Order, are as follows: forty five (45) percent of the great toe; eight (8) percent of the foot; six (6) percent of the lower extremity; and two (2) percent of the whole person.

2. Employer/Carrier shall pay Claimant compensation for permanent total disability from February 27, 2002 through June 8, 2002, based on an average weekly wage of $1082.50., in accordance with the provisions of Section 8(c) of the Act. 33 U.S.C. § 908(c)(8)(19). The impairment ratings to be used in this calculation, as reflected in this Decision and Order, are as follows: forty five (45) percent of the great toe; eight (8) percent of the foot; six (6) percent of the lower extremity; and two (2) percent of the whole person.

3. The date of maximum medical improvement (MMI) with respect to Claimant's left great toe is February 26, 2002.

4. Employer/Carrier shall pay to Claimant the annual compensation benefits increase pursuant to Section 10(f) of the Act effective October 1, 2002, for the applicable period of permanent total disability.

5. Compensation for all other injuries (including lumbar spine, diabetes mellitus, diabetic retinopathy, and psychiatric illness) and any treatment associated therewith is denied.

6. Employer shall receive credit for all compensation heretofore paid, as and when paid.

7. Employer shall pay interest on any sums determined to be due and owing at the rate provided by 28 U.S.C. § 1961 (1982); ***Grant v. Portland Stevedoring Co., et al.***, 16 BRBS 267 (1984).

8. The District Director shall make all necessary calculations to effectuate this **ORDER.**

9. Claimant's attorney shall have thirty (30) days to file a fully supported fee application with the Office of Administrative Law Judges; a copy must be

served on Claimant and opposing counsel who shall then have twenty (20) days to file any objections thereto.

10. All matters relating to Section 8(f) of the Act are moot, since I have determined that Claimant failed to prove any aggravation of a pre-existing injury on account of the March 22, 2001 accident.

SO ORDERED

A

DANIEL F. SOLOMON
Administrative Law Judge